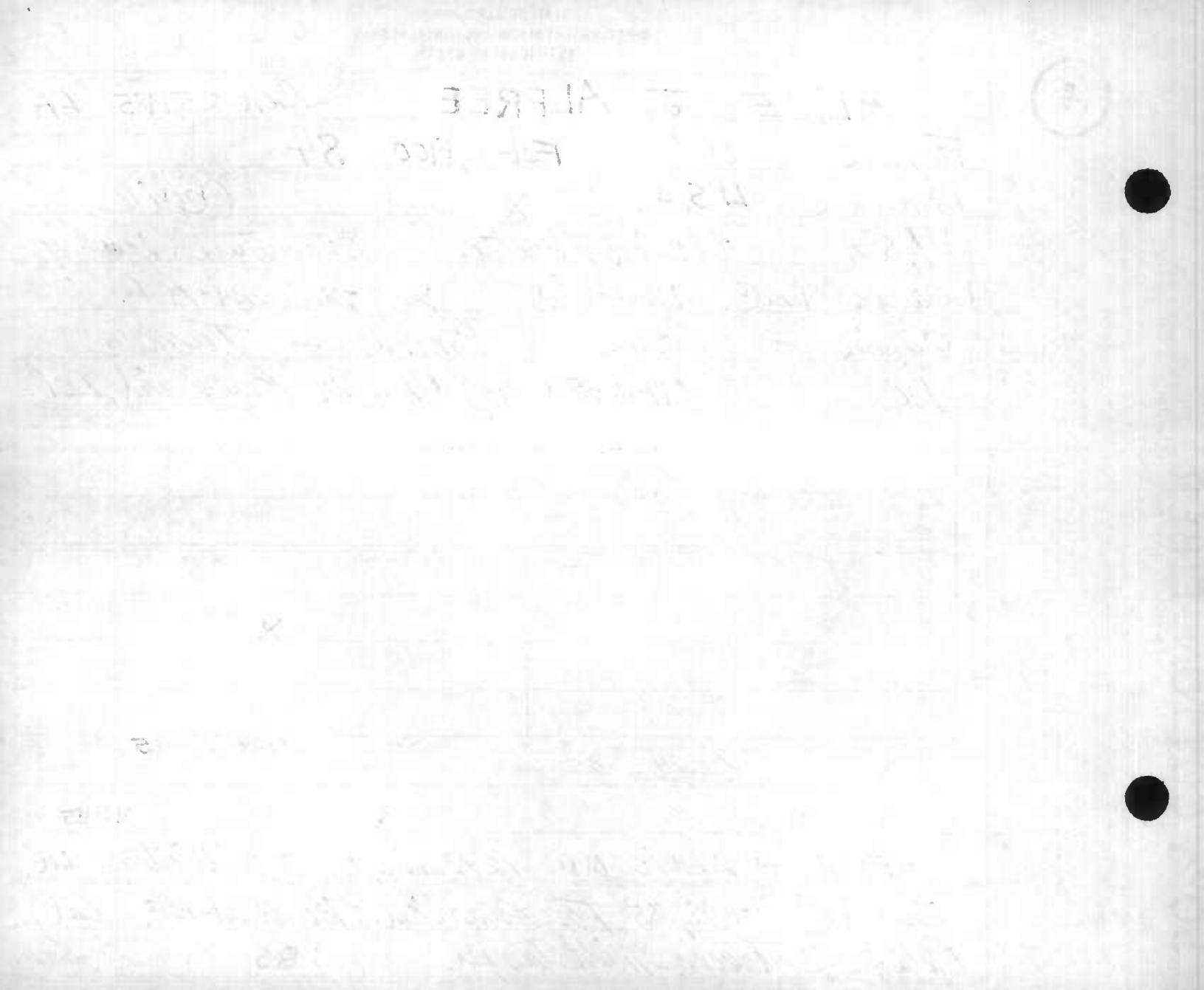


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Please mark 2 should be filled within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be called and informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85	01	822			
										REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Jan 25, 1985			6A M			
ALICE J. ALFREE															
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS MONTHS HOURS MIN.		
Female			W		Feb 2, 1900		84								
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil			12a. VISUAL OCCUPATION (TYPE OF WORK FOR MOST PLEASING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY Seamstress Laundry		
Delaware			U.S.A.												
10. CITY OR TOWN OF DEATH Elton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Union Hospital		12b. STREET ADDRESS Towmout-R.D.										
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13. CITY OR TOWN Delaware N.C. Blackbird			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS Towmout-R.D.						
14. FATHER'S NAME Emilee - Jones			15. MOTHER'S MAIDEN NAME Emma - Tucker			16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 217-22-8500			17. INFORMANT Roy Alfree, Dr. - Blackbird, Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension 26 yrs service			DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 3/14, 1984, to 1/24, 1985, that (I) (we) last saw the deceased alive on 1/24, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Kenneth Lewis MD			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 1/28/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS, MD.			22e. ADDRESS 12 Pennington St Middletown, Del.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Jan 28, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Towmson Cem.			23d. LOCATION TOWNSHIP OR TOWN MIDDLETOWN, DEL. COUNTY STATE						
24. FUNERAL DIRECTOR Robert C. Statler - Middletown, Del.									25a. DATE REC'D. BY REGISTRAR JAN 31 1985			25b. REGISTRAR'S SIGNATURE John Wilson Pendleton			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be dated within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other traumatic event, which may have contributed to the death.

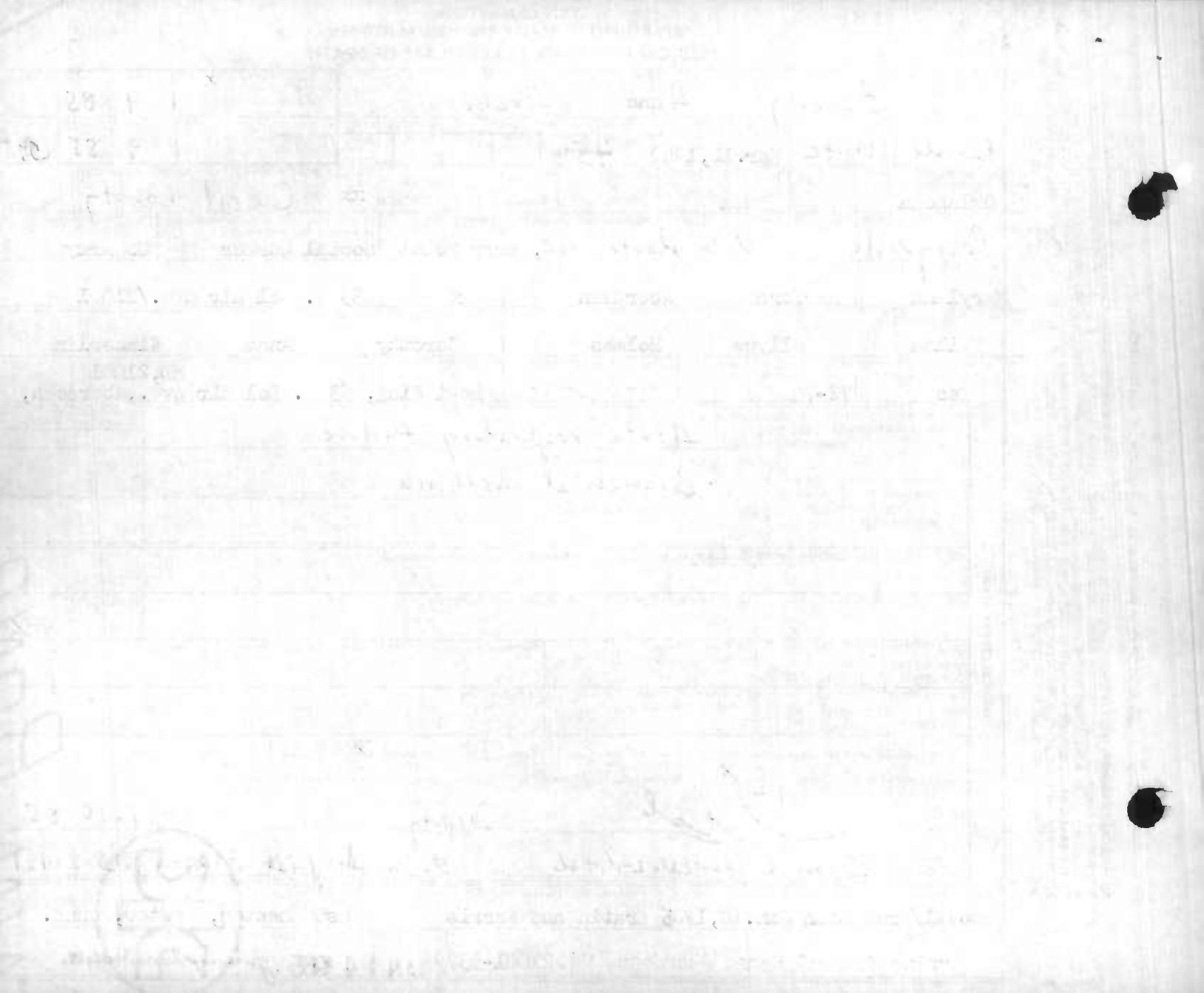
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 01823								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
JOSEPH			A.			ANNECHINO						January 21, 1985					12:05 pm			
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE		IN YEARS LAST BIRTHDAY		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			WHITE			MONTH DAY YEAR			JAN. 19 1928			57		YEARS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.						9. BALTIMORE CITY OR COUNTY OF DEATH								
PENNA.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						Cecil County		MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY								
Perry Point, Md.			VA Medical Center			MAINTENANCE						STEVENS CO.								
13a. STATE MD.			13b. COUNTY			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4800 PARKSIDE DRIVE 21206								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
JOSEPH						ANNECHINO			ROSE						D'ORAZIO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS		SAME						
YES			1946-1947			216-20-2627			CARMEN ANNECHINO (BROTHER)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 16, 1984, to January 21, 1985, <u>XXXXXXXXXXXX</u> <u>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 1-21-85								
22b. SIGNATURE <i>Joséquin R. Garcia</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF STAFF PHYSICIAN <input checked="" type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. GARCIA, M.D.			22e. ADDRESS VA Medical Center, Perry Point, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/24/85			23c. NAME OF CEMETERY OR CREMATORIAL HOLY REDEEMER			23d. LOCATION CITY OR TOWN BALTO.			STATE MD.								
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Baltimore, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 23 1985			25b. REGISTRAR'S SIGNATURE <i>Lia Swanson-Randall</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 11 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	2b. MONTH	DAY	YEAR	2b. HOUR																			
Beverly			Anne			Archer						<input checked="" type="checkbox"/>				1985																			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR																			
Female		White		Mar. 12, 1940		45 yrs.						1985		1985		16:30 P.M.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Oklahoma			USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Cecil County			Perryville			U.S. Route 40, Perry Point			Social Worker			US Army														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME FIRST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES <input checked="" type="checkbox"/> 72-74			16b. SOCIAL SECURITY NO. 442-40-9258			17. INFORMANT Vicki King, 453 W. Bel Air Ave., Aberdeen,			MD, 21001					
Maryland			Harford			Aberdeen						453 W. Bel Air Ave./21001			Vilna			Dorothy			Anne			Ollyce			Holmes			Acute respiratory failure			Kimberlin		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			(b)			(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY?																	
																		<input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE																				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE			TITLE (SPECIFY) M.D. Deputy															MEDICAL EXAMINER			DATE SIGNED														
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS															Union Hospital, Elkton, MD 21921																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE																				
Removal/Cremation			Jan. 10, 1985			Cratin and Ferris			West Chester, Chester, Penna.																										
24. FUNERAL DIRECTOR NAME			ADDRESS															25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Tarring Funeral Home, Aberdeen, Md. 21001-3399																		JAN 14 1985			Julia Davidson-Pendall														
DHMH - 17 (VR A15 ME (5))																																			
20M 4/82																																			

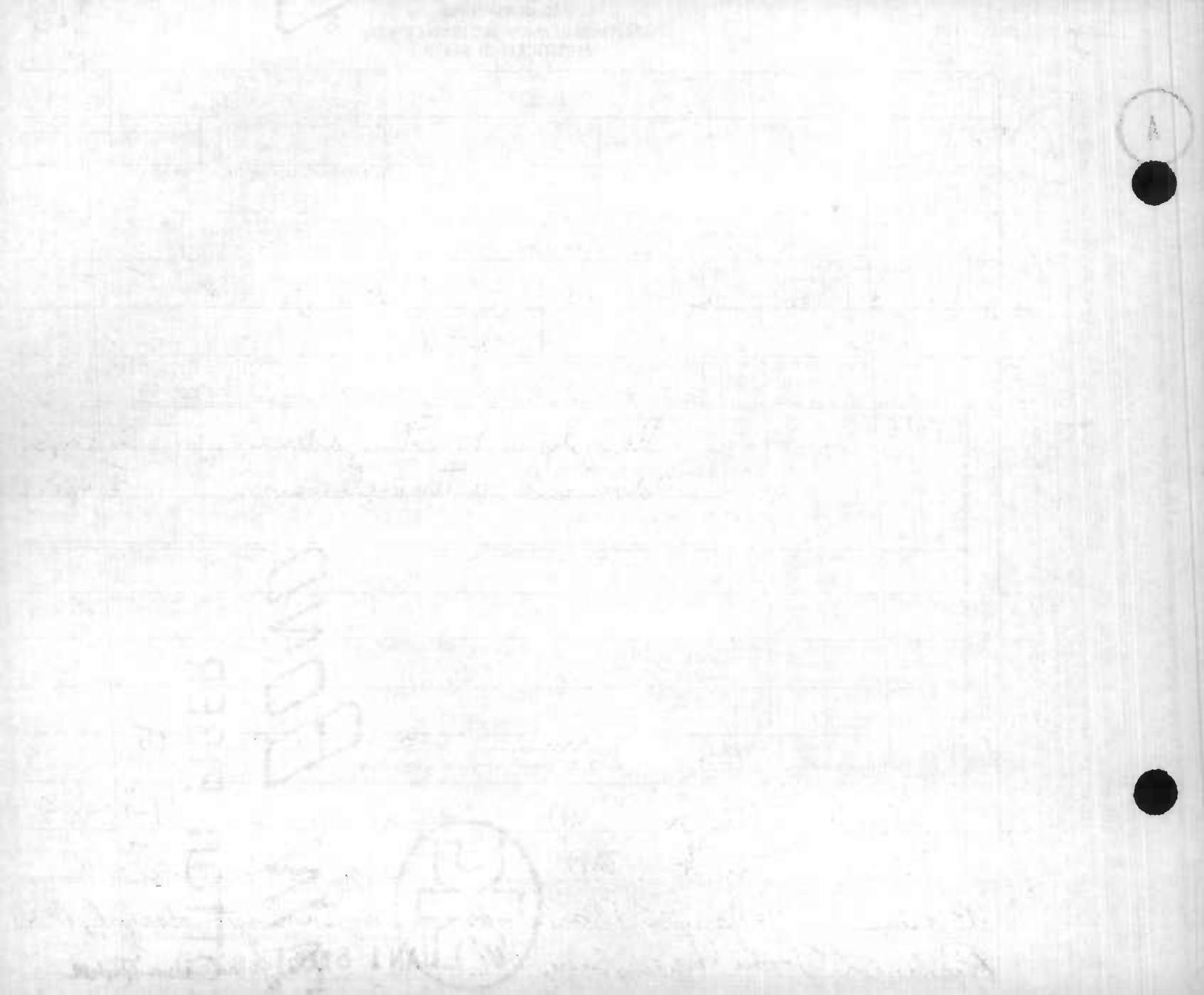


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please

(O FUNERAL DIRECTOR): After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper, place in 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the physician must sign this section.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501825					
1 - FOR STATE REGISTRAR										REG. NO.					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Nina			R.	Ashton		Jan. 10, 1985						9:05A.M.			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			White		MONTH DAY YEAR			98			IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.				
Indiana			USA					Cecil			MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Rising Sun			Calvert Manor Nursing Home			Housewife			99999						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Pa.			Chester		Lincoln Univ.			R.D. #1, Box 97							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS			COPPOCK			
Hadley					Reeve	Adeline			Lincoln Univ., Pa.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			212-74-3093			Catherine Graybeal, R.D.#1, Box 97			Congestive heart failure Advanced arteriosclerosis			2 days 5 yrs.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> 19 <u>85</u> to <u>1-9</u> 19 <u>85</u> , that (I) (we) lost sow the deceased alive on <u>1-9</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Neil Taylor MD			22e. ADDRESS			Rising Sun, Md.			1-10-85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Burial			14 Jan. 85			Darlington Cemetery, Darlington, Harford, Md.									
24. FUNERAL DIRECTOR NAME													25a. DATE REC'D. BY REGISTRAR		
Richard L. Goode													JAN 16 1985		
Rising Sun, Md.													Julia Davidson, Registrar		



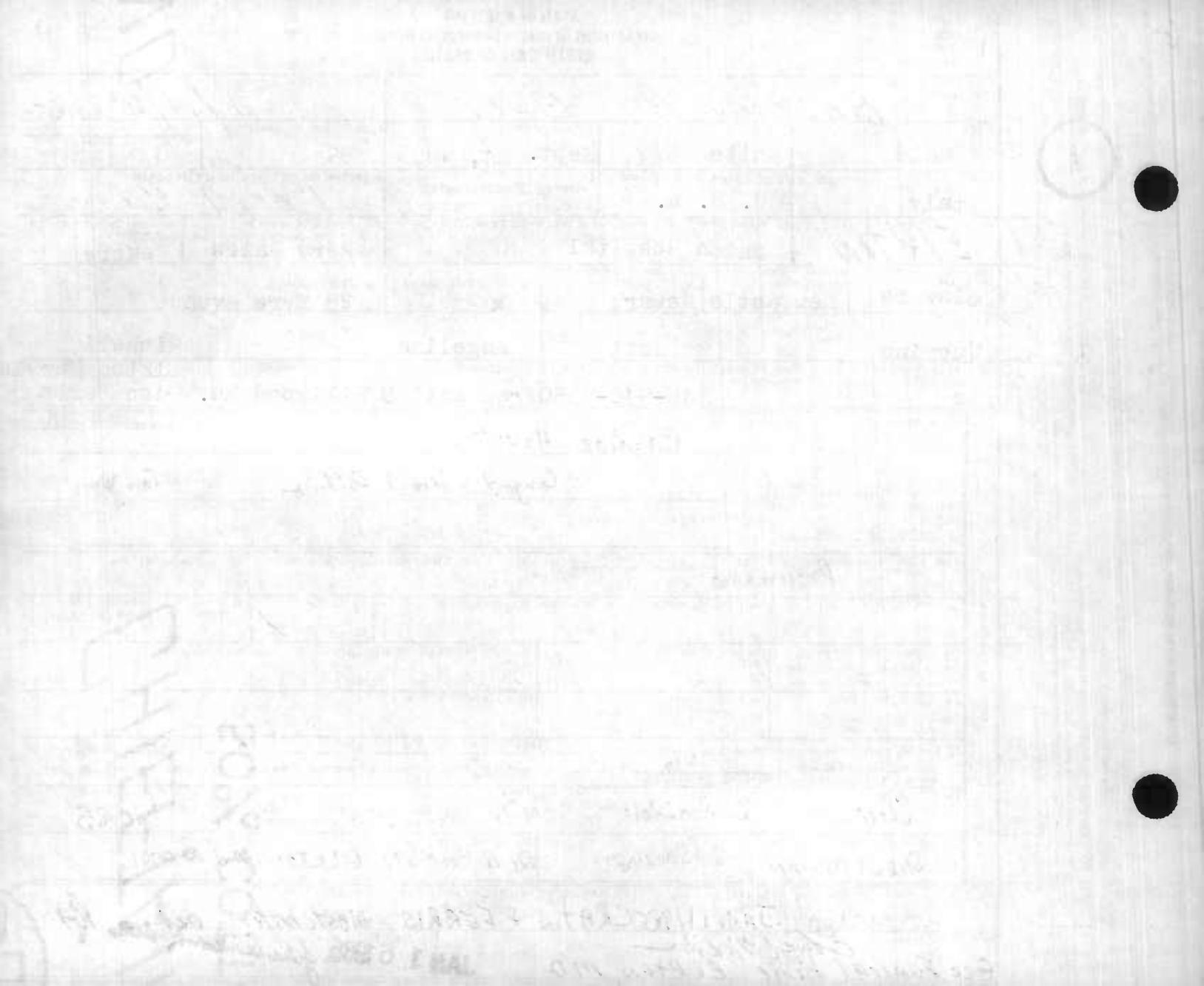
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8501826								
												REG. NO.								
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH	DAY	YEAR	2b. HOUR					
Anthony A Asti												Sept.	24	1895	11/10/85 09:35 M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS					
Male			White			MONTH Sept.			YEAR 89			MONTHS	DAYS	YEARS	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD											
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bakery Sales			12b. KIND OF BUSINESS OR INDUSTRY Bakery											
13a. STATE Delaware			13b. COUNTY NewCastle			13c. CITY OR TOWN Newark			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 28 Tyre Avenue 99999								
14. FATHER'S NAME FIRST Guerino			MIDDLE			LAST Asti			15. MOTHER'S MAIDEN NAME FIRST Angelina			MIDDLE			LAST Micheli					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few years					
No			16-910-9350			Fran Asti 9 Hillwood Rd. Glen Farms														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure			(c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/10 1985, to 1/10 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.																				
22b. SIGNATURE Sheelman S. Sachdev			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/10/85.											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHEELMAN S. SACHDEV			22e. ADDRESS 204 Bow St, ELKTON MD 21921																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE JAN. 11/1985			23c. NAME OF CEMETERY OR CREMATORIUM CRATIN + FERRIS			23d. LOCATION CITY OR TOWN Westchester			COUNTY STATE								
24. FUNERAL DIRECTOR NAME Edward McClain ADDRESS Gee Funeral Home ELKTON, MD.									25a. DATE REC'D. BY REGISTRAR JAN 1 6 1985 John Davis			25b. REGISTERED BY John Davis								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												5	01827						
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR		
Elizabeth			Kibler			Bakeoven			<input type="checkbox"/>					14 1985		M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY		6. AGE (IN YEARS YEAR LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR		
Female		White		4 7		05 79		MONTHS		DAYS		HOURS		1 4 1985		3:45 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Va.		U.S.A.		957 old Philadelphia Road		Nurse Aid		Cecil County, MD.		North East		957 old Philadelphia Road		21901					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST		15. MOTHER'S MAIDEN NAME FIRST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Md.		Cecil		North East		NO		957 Old Phila Rd.		Claud D. Kibler		Mary Ella Burner		NO		213-20-1628		John S. Dean 51 Deans La.	
																		North East, Md. 21901	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <i>Atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.																			
(b) <i></i> DUE TO, OR AS A CONSEQUENCE OF																			
(c) <i></i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER							
ACTUAL SIGNATURE <i>Juan C Gonzalez-Vital</i>												DATE SIGNED <i>1-4-85</i>							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS																
Juan C Gonzalez-Vital MD			Union Hospital Elkton, MD 21921																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1-7-85			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN										
Burial						North East Meth.			North East Cecil Md.										
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE													
Crouch Funeral Home			North East, MD			JAN 7 1985			<i>Julia Davidson-Pendleton</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use in the burial trust. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to Burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8501828			
1 - STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mark	MIDDLE D.	LAST Brown		2. DATE OF DEATH MONTH January DAY 18 YEAR 1985 HOUR 10:20am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Jan. DAY 20 YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 yrs. YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7. BIRTHPLACE (STATE OR FOREIGN (COUNTRY) Kentucky		8. CITIZEN OF WHAT COUNTRY? U.S.A.		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perryville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 97 Browns Road		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) P.M. & R.		12b. KIND OF BUSINESS OR INDUSTRY V.A.M.C., Perry Point, Md.			
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 97 Browns Road 21903			
14. FATHER'S NAME FIRST Thomas		MIDDLE J.	LAST Brown	15. MOTHER'S MAIDEN NAME FIRST Dulcenia		MIDDLE --- LAST Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 406-09-9146		17. INFORMANT Helen W. Brown		ADDRESS 97 Brown Rd., P.O. Box 59 Perryville, Maryland 21903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		BRONCHIESTASIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 YR.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE				20 YR.			
{		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
SEVERE DEPRESSION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 17</u> , 1984, to <u>TAN 22</u> , 1985, that (I) (we) last saw the deceased alive on <u>TAN 9</u> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							22b. DATE SIGNED 1-19-85		
22b. SIGNATURE Andrew P. Fridberg, M.D.		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew P. Fridberg, M.D.		22e. ADDRESS 502 Lewis St., Havre de Grace, Md. 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 21, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Angel Hill Cem.		23d. LOCATION CITY OR TOWN Havre de Grace			STATE Md.
24. FUNERAL DIRECTOR See A. Patterson & Son, Perryville, Md.				25a. DATE REC'D. BY REGISTRAR JAN 25 1985		25b. REGISTRAR'S SIGNATURE Julia L. Wilson-Patterson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						85 01829	
						REG. NO.	
1 - FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OF PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Helen T. Carter				Jan. 31, 1985		7:55 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Aug. 16, 1911		73	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		US				Cecil	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rising Sun		Calvert Manor Nursing Home, Inc.				Housewife	
13a. STATE PA		13b. COUNTY Chester		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						13e. STREET ADDRESS / ZIP CODE 227 E. Mt. Vernon St. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Ralph Tubbs		Emma				Watkins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
No		181-03-6902				Donald Carter, 203 Kelton Rd., West Grove Pa. 19390	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i>						3 weeks	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>stroke, small</i>						4 weeks	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alzheimer's Disease</i>						many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>inability to swallow, feeding tube</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 21</u> 1985, to <u>Jan 31</u> 1985, that (I) (we) last saw the deceased alive on <u>Jan 21</u> 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) care for the body after death.							
22b. SIGNATURE <i>Faye R. Doyle MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Faye R. Doyle, MD.		22e. ADDRESS 133 Locust St. Oxford, Pa.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/85		23c. NAME OF CEMETERY OR CREMATORIAL Oxford Cemetery		23d. LOCATION CITY OR TOWN Oxford COUNTY Chester STATE Pa.	
24. FUNERAL DIRECTOR <i>Richard L. Goodie</i>		25a. DATE REC'D. BY REGISTRAR FEB 8 1985		25b. REGISTRAR'S SIGNATURE <i>Gilia Davidson-Randall</i>			

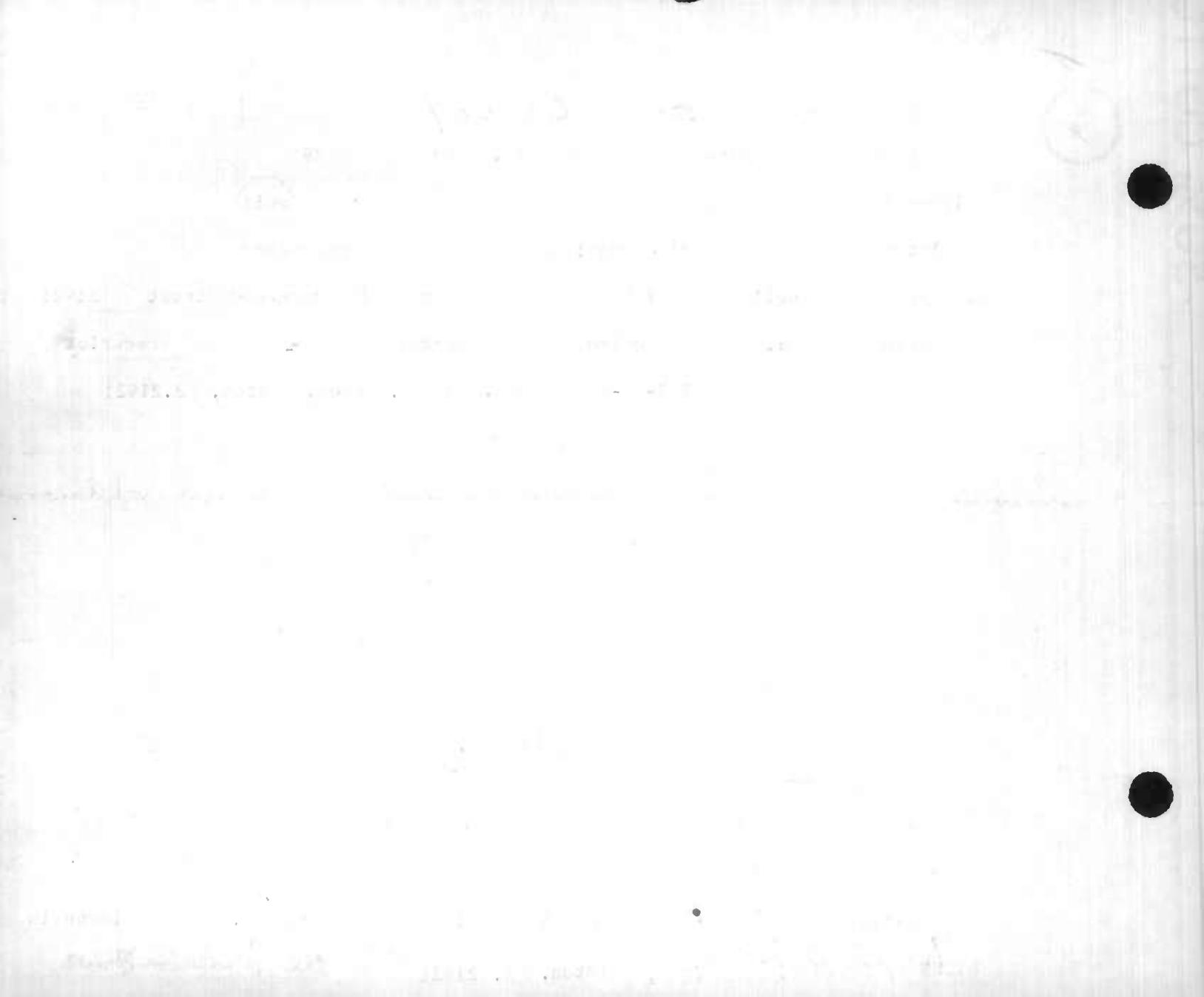
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 26 is checked any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501830											
1. FOR STATE REGISTRAR										REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR												
ESTHER B. COOLEY						1 1 85			1120 A.M.												
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.									
Female		White		JUNE 21, 1895			89														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
Wisconsin		USA					Cecil														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Elkton		Union Hospital		Homemaker																	
13a. STATE Maryland										13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 71 Greenwood Street 21921					
14. FATHER'S NAME FIRST John		MIDDLE J.		LAST Mueller		15. MOTHER'S MAIDEN NAME FIRST Bertha		MIDDLE -		LAST Frederick											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
No		393-03-9300D		Mrs. Hope B. Beach, Elkton, Md. 21921				20 min.													
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY																					
IMMEDIATE CAUSE (a) Cardiac arrest																					
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										31 d.											
DUE TO, OR AS A CONSEQUENCE OF (c) Anterior atherosclerotic heart disease																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes mellitus; cerebral vascular disease																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		12/1/1984 to 1/1/1985																			
above, (I) (we) did not <input type="checkbox"/> view the body after death.		19/85																			
22b. SIGNATURE Edgar E. Folk III		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/1/85															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk III		22e. ADDRESS Union Hospital, Elkton, Md. 21921																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 4, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Fassett Cemetery		23d. LOCATION CITY OR TOWN Edgerton,		COUNTY		STATE Wisconsin											
24. FUNERAL DIRECTOR Hicks Home for Funerals, P.A.		ADDRESS Elkton, Md. 21921		25a. DATE REC'D. BY REGISTRAR JAN 7 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton															
BP _____																					
DHMH - 16 50M 4/83 (VRA 15, 4)																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No", Item 18 shows only injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 8 3 1			
1. FOR STATE REGISTRAR										REG. NO.			
I. DECEASED NAME FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
Winnie Crowl										January 5, 1985	9:30A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
White		White		Sept. 1, 1898		86		YRS.		MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Wilmington, Del.		USA		MARRIED NEVER MARRIED WIDOWED DIVORCED		Cecil County		Housewife					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		Home					
Elkton		Devine Haven Nursing Home		Housewife		224 East Main Street		01901					
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES NO		13e. STREET ADDRESS	
Md.		Cecil		Elkton		YES		224 East Main Street					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
William S. Davis		Agatha Gaettler		No		210-28-2908		Mrs. Elizabeth D. Tolwinski		Little Egypt Rd. Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sensitivity</u> . <u>graceinse</u> .													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe</u> <u>generalized arteritis</u> .													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital) attended the deceased from 10/22/72, 1972, to 1/5/85, that (I) (we) last saw the deceased alive on 1/1/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE DEGREE										22c. DATE SIGNED			
Jui Chih Hsu MD										1/17/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS									
223 West Main St. Elkton, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Cremation		1-7-85		Gratn & Morris		West Chester		Chester		Pa.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Edward McLean		Elkton, Md.		JAN 1 0 1985		Julia Davidas							
Gee Funeral Home													



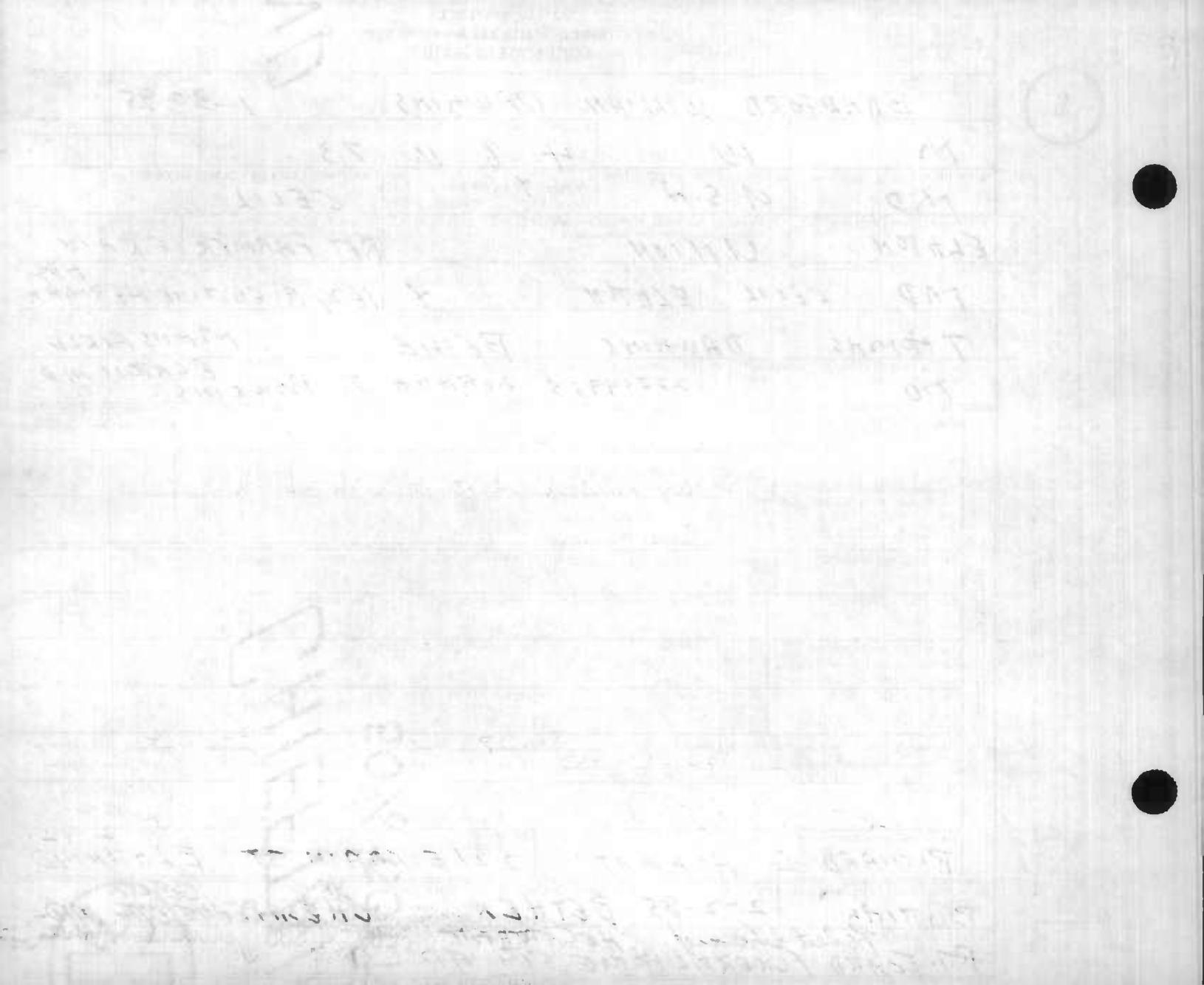
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8501832											
1. FOR STATE REGISTRAR			REG. NO.																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
BRADFORD WILLIAM DAWKINS												1-30-85					M						
3. SEX <i>M</i>			4. RACE <i>W</i>			5. DATE OF BIRTH MONTH <i>4</i> DAY <i>6</i> YEAR <i>11</i>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>73</i>			IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS DAYS <i>0</i> HOURS <i>0</i> MIN. <i>0</i>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>CECIL</i>			10. CITY OR TOWN OF DEATH <i>ELKTON</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>URION</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RET FARMER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>GRAIN</i>		
13a. STATE <i>MD</i>			13b. COUNTY <i>CECIL</i>			13c. CITY OR TOWN <i>ELKTON</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>21921 HDE 1679 AUGUSTINE HERMAN</i>											
14. FATHER'S NAME FIRST <i>J. HORNIS</i>			MIDDLE <i>DAWKINS</i>			LAST			15. MOTHER'S MAIDEN NAME FIRST <i>BESSIE</i>			MIDDLE <i>DAVIS FIELD</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>222-09-8380</i>			17. INFORMANT <i>LORANA J. DAWKINS</i>			ADDRESS <i>ELKTON MD</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>																							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction with shock</i>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 28</i> 19 85 to <i>Jan 30</i> 19 85, that (I) (we) last saw the deceased alive on <i>Jan 29</i> 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>K. S. Ackart</i>															DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2-1-85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RICHARD S. ACKART</i>															22e. ADDRESS <i>221 E. MAIN ST. ELKTON MD</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIA</i>			23b. DATE <i>2-2-85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>BETHESDA</i>			23d. LOCATION CITY OR TOWN <i>CECIL</i>			CITY OR TOWN <i>CECIL</i>			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME <i>Robert J. Hornis</i>			24b. ADDRESS <i>THE SATELLITE RICHARD FURNACE HOME CITY OF</i>			25a. DATE REGD. BY RET'D. REG'D. OR 25b. REG'D. BY <i>EUO 4 1985</i>			25b. REG'D. BY <i>John W. Hornis</i>														

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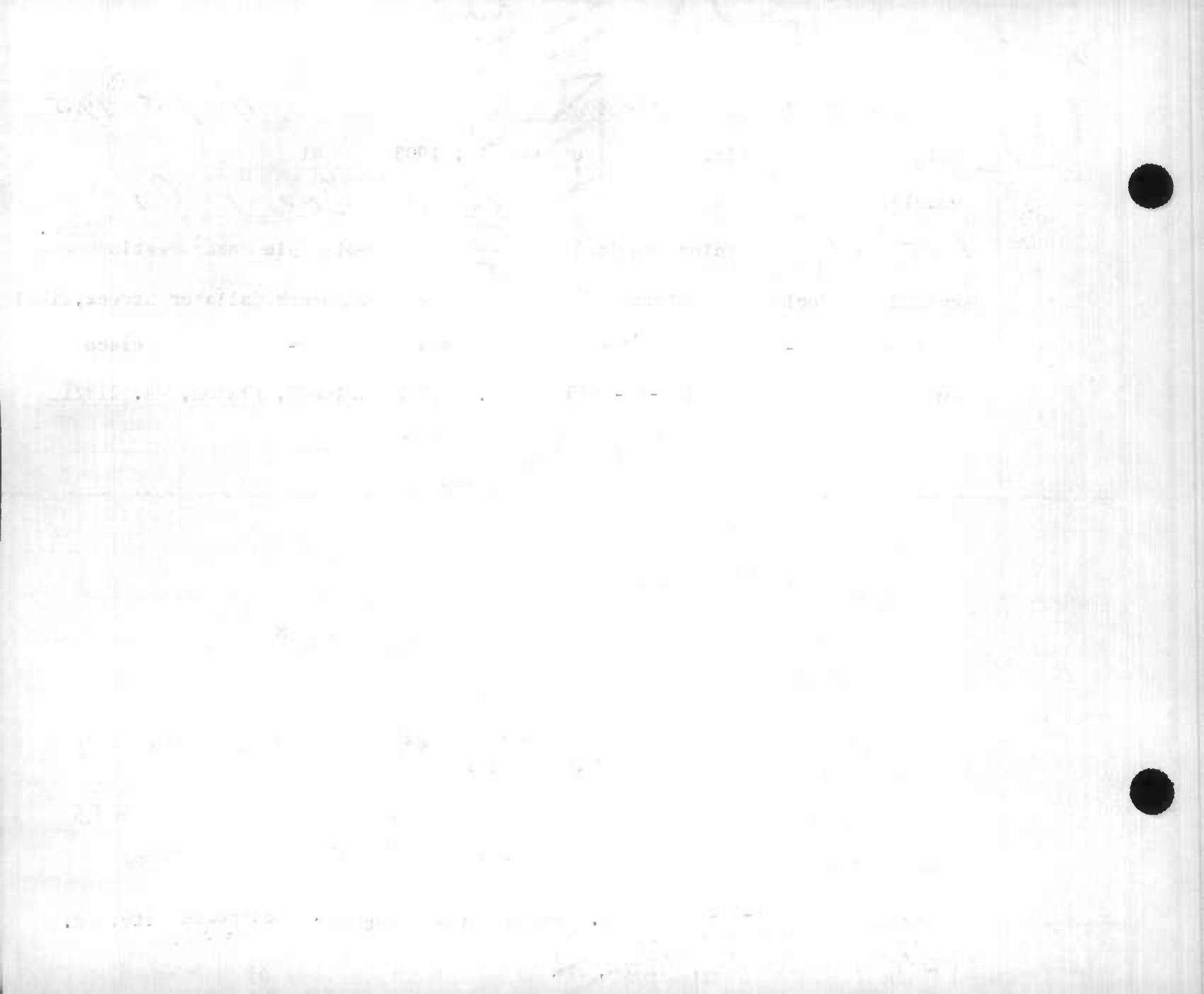


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for us as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 8 3 3			
										REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		MONTH	DAY	YEAR	2b. HOUR	
Maed THOMAS DeManincor									February	14	1903	11/13/85 1915 M	
3. SEX			4. RACE		5. DATE OF BIRTH							6. AGE (IN YEARS LAST BIRTHDAY)	
Male			White		MONTH DAY YEAR							81 yrs	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							9. BALTIMORE CITY OR COUNTY OF DEATH	
Austria			USA									Cecil Co	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Elkton			Union Hospital							Tool & Die Maker			Corp. Westinghouse
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton							9 Joseph Gallaher Street, 21921				
14. FATHER'S NAME FIRST Samuel			MIDDLE		LAST deManincor		15. MOTHER'S MAIDEN NAME FIRST Mary			LAST Reisco			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
No			195-16-6365		Mrs. Mary deManincor, Elkton, Md. 21921								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Respiratory Failure													
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
Rt Hemiplegia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			P.M. 19										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above (I) (we) (did) (did not) view the body after death.			Sept. 19 84 to 1.13 19 85							that (I) (we) last			
22b. SIGNATURE Sheelman S. Sashaw			DEGREE M.D.							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1.16.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheelman S. Sashaw			22e. ADDRESS 204 Bow St, Elkton MD 21921										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-16-85		23c. NAME OF CEMETERY OR CREMATORIAL St. Rose of Lima Cemetery, Chesapeake City, Md.		23d. LOCATION CITY OR TOWN			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Hicks			ADDRESS Hicks Home for FUNERALS, ELKTON, MD.							25a. DATE REC'D. BY REGISTRAR JAN 21 1985			25b. REGISTRAR'S SIGNATURE K. H. Hicks



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified of it.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 1 8 3 4			
1. FOR STATE REGISTRAR				20. DATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	MONTH		DAY	MONTH	DAY	YEAR	2b. HOUR				
Hazel m. DeMull				DEMULL	FEBRUARY		27	11	18	85	10 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
FEMALE		WHITE		MONTH DAY YEAR		MONTHS DAYS		MONTHS	YEARS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY					
MARYLAND		USA		FEBRUARY 27, 1915				Cecil		MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Elkton		Laurelwood Nursing Center										HOMEMAKER			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY					
MD		HARFORD		HAVRE de GRACE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		135 WILSON STREET		21078					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		LAST								
		CHARLES		BAGENT	REBA		MCGONIGAL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		216 80 1798		HARRY J. DeMULL		SAME AS #13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>County Major and child first</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Altered tolerance - GSHD</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/18/85</i> to <i>1/18/85</i> , that (I) (we) last saw the deceased alive on <i>1/18/85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>John J. Lanza</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-18-85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH G. LANZA</i>		22e. ADDRESS <i>721 BRIDGE ST. ELKTON, MD 21921</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 21 JANUARY 85		23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN HAVRE de GRACE, HARFORD CO., MD		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 21 1985		25b. REGISTRAR'S SIGNATURE <i>Julie Lander Pendell</i>									

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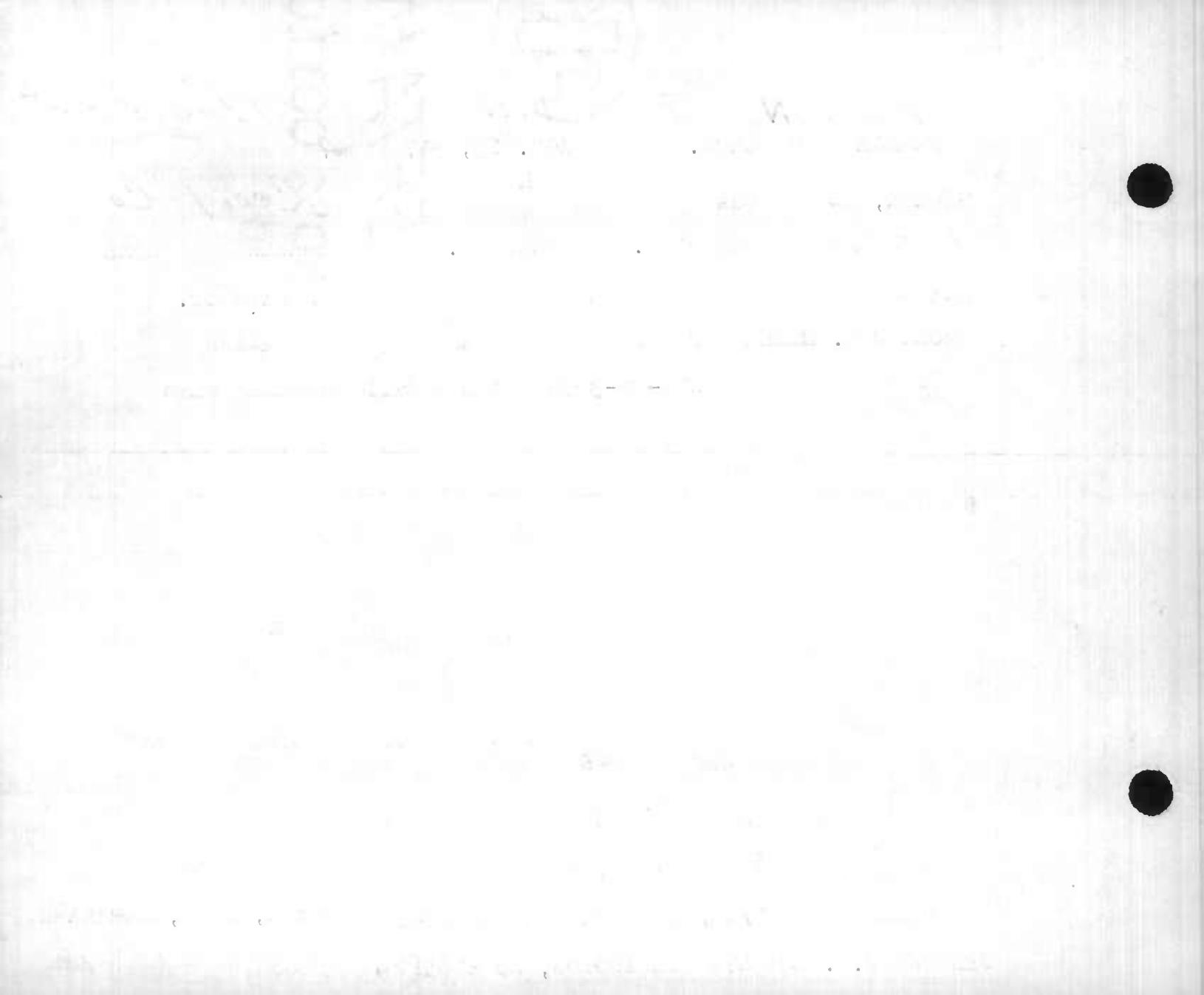
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IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8501835
						REG. NO. 1
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH 1/26/85			2b. HOUR 4:25 P.M.
1. DECEASED NAME LAST (TYPE OR PRINT) MARIAN P. DILL			3. SEX MIDDLE FEMALE FIRST			4. RACE CAUC.
5. DATE OF BIRTH YEAR NOV. 15, 1917			6. AGE MONTHS 67 YEARS (LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS
8. BIRTHPLACE IF UNDER 24 HRS. COUNTRY GALENA, MD			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL CO. MD.			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL CO. MD.
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ELKTON UNION HOSP. OF CECIL CO.			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND COUNTY KENT			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER
13a. CITY OR TOWN 13b. STREET ADDRESS / ZIP CODE GALENA NORTH MAIN ST. 21635			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE NORTH MAIN ST. 21635
14. FATHER'S NAME 15. MOTHER'S MIDDLE NAME ROLAND R. EXXX PENNINGTON MARY			16. SOCIAL SECURITY NO. 17. INFORMANT 218-01-3058 WILSON DILL husband same			15. MOTHER'S LAST NAME QUINN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. NO			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any			(b) <u>chronic Obstructive Lung Disease</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 o						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>1/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. DEGREE <u>John Rosenfeld MD</u>		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>1/26/85</u>
22e. ADDRESS <u>John Rosenfeld MD</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/29/85		23c. NAME OF CEMETERY OR CREMATORIUM GALENA CEMETERY		23d. LOCATION GALENA, KENT, MARYLAND
24. FUNERAL DIRECTOR NAME FELLOWS F.H.		25a. ADDRESS BOX 270 MILLINGTON, MD 21655		25b. DATE REC'D. BY REGISTRAR FEB 0 5 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 20 shows any injury, or other traumatic event, the medical examiner must be retained or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 1 8 3 6											
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME FIRST John			MIDDLE K.			LAST Dooley			2a. DATE OF DEATH MONTH January			DAY 4	YEAR 1985	2b. HOUR 4:45 A.M.						
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH Oct.			DAY 25			YEAR 1901			6. AGE (IN YEARS LAST BIRTHDAY) 83			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.			
7a. BIRTHPLACE Scotland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County			10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co.			12a. USUAL OCCUPATION Retired			12b. KIND OF BUSINESS OR INDUSTRY Sun Oil		
13a. STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 69 Wood Duck Lane			21981								
14. FATHER'S NAME FIRST William			MIDDLE J.			LAST Dooley			15. MOTHER'S MAIDEN NAME FIRST Margaret			MIDDLE			LAST Dempster								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 163-09-6016			17. INFORMANT John Vernon Dooley			ADDRESS 136 W. Thomson Dr.			Elkton Md.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocard infarction.</u>																							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD. (Advance).</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD.</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that <u>John</u> (this hospital) attended the deceased from <u>12/8</u> , 19 <u>72</u> , to <u>1/4</u> , 19 <u>85</u> , that <u>John</u> (we) last saw the deceased alive on <u>1/3</u> , 19 <u>85</u> , and that in <u>John</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>John</u> (we) did (did not) view the body after death.																							
22b. SIGNATURE <u>See my file</u>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/4/85								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jui chih Hsu</u>			22e. ADDRESS 223 west main st. Elk. MD																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 7 1985			23c. NAME OF CEMETERY OR CREMATORIAL LawnCroft Cemetery			23d. LOCATION CITY OR TOWN Linwood			COUNTY Del.			STATE PA.								
24. FUNERAL DIRECTOR NAME <u>Edmund M. Allen</u> ADDRESS <u>Gee Funeral Home</u>									25a. DATE REC'D. BY REGISTRAR JAN 1 1985			25b. REGISTRAR'S SIGNATURE <u>See my file</u>											

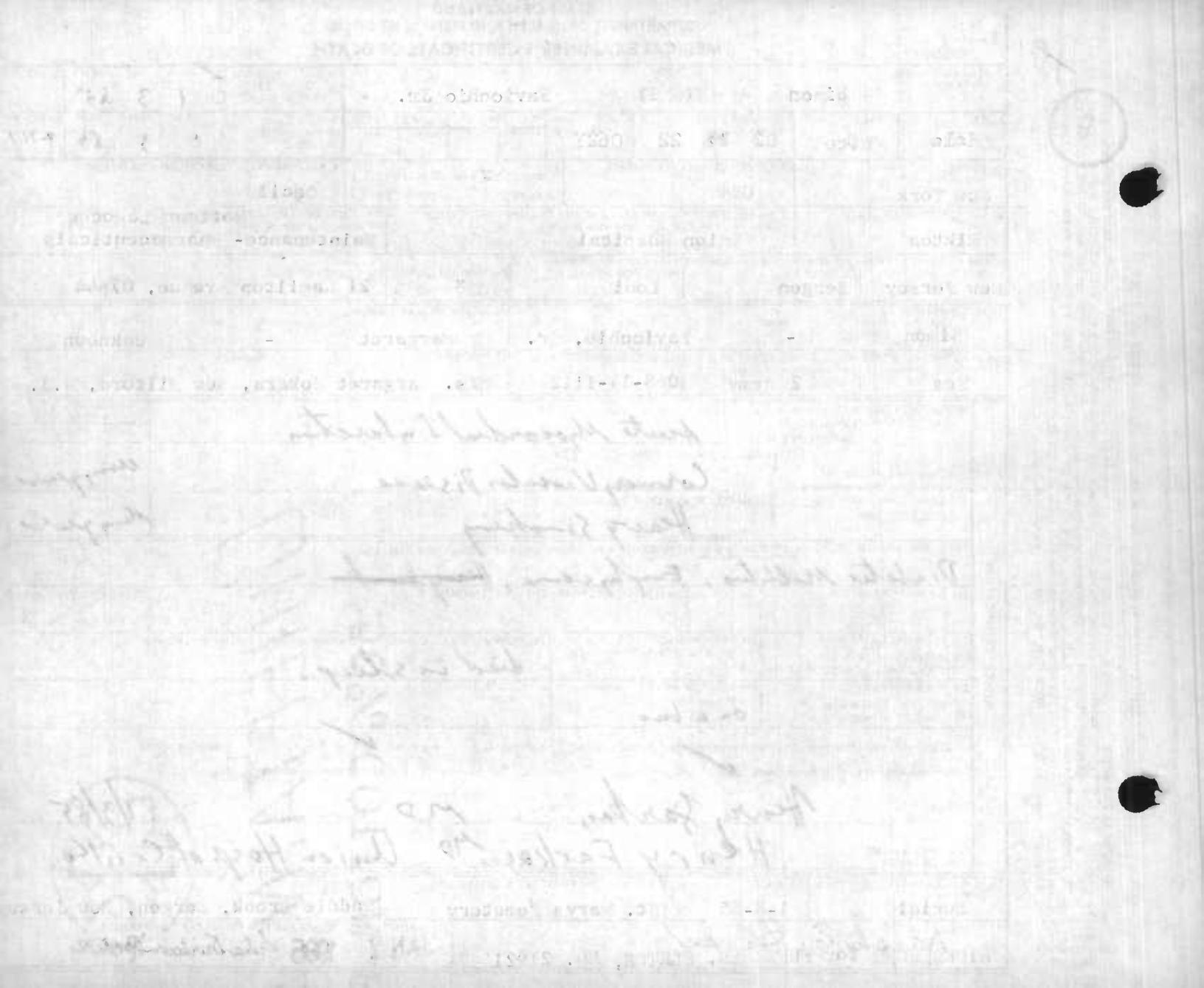
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. THE EXAMINER SHOULD BE NOTIFIED AS SOON AS POSSIBLE. THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. THE EXAMINER SHOULD BE NOTIFIED AS SOON AS POSSIBLE.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 1 8 3 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR					
Simon		(NMI)		Favicchio Jr.				<input checked="" type="checkbox"/>		1		3		1985					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 02 DAY 23 YEAR 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 yrs.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9. DATE Pronounced Dead		MONTH		DAY		YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil		10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE Maintenance- Pharmaceuticals		12b. HOUR Hoffman Leopold		12c. HOUR MD.			
13a. STATE New Jersey		13b. COUNTY Bergen		13c. CITY OR TOWN Lodi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21 Hamilton Avenue, 07644		13f. KIND OF BUSINESS OR INDUSTRY 99999									
14. FATHER'S NAME FIRST Simon		MIDDLE		LAST Favicchio, Sr.		15. MOTHER'S MAIDEN NAME FIRST Margaret		16. SOCIAL SECURITY NO. 068-14-1112		17. INFORMANT Mrs. Margaret Bokara, New Milford, N.J.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>Coronary Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heavy Smoking</u> DUE TO, OR AS A CONSEQUENCE OF		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many years					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2 Army		16c. INFORMANT Mrs. Margaret Bokara, New Milford, N.J.		19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Diabetes Mellitus, Emphysema, Heavy smoking		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) died in sleep		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on a bus		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) ACTUAL SIGNATURE <u>Henry Farkas</u> , M.D.		22c. MEDICAL EXAMINER		22d. DATE SIGNED 1/3/85													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-8-85		23c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cemetery		23d. LOCATION CITY OR TOWN Saddle Brook, Bergen, New Jersey		23e. DATE REC'D. BY REGISTRAR JAN 7 1985		23f. REGISTRAR'S SIGNATURE Julia Davidson Pendall									
24. FUNERAL DIRECTOR NAME HICKS HOME FOR FUNERALS, ELKTON, MD. 21921		24b. ADDRESS		24c. ADDRESS		24d. ADDRESS		24e. ADDRESS		24f. ADDRESS									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8501838

1. DECEASED NAME (TYPE OR PRINT)			FIRST Vanis	MIDDLE W	LAST FUNK	2a. DATE OF DEATH MONTH 10	DAY 07	YEAR 07	2b. HOUR 11 26/85 1030 AM		
3. SEX male			4. RACE white		5. DATE OF BIRTH MONTH 10	DAY 07	YEAR 07	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.				
10. CITY OR TOWN OF DEATH ELKTON Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION Hosp Cecil County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer				12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 316 B Nottingham Road 21921		
14. FATHER'S NAME FIRST William			MIDDLE H.	LAST Funk	15. MOTHER'S MAIDEN NAME FIRST Bessie				MIDDLE -	LAST Henry	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-01-6104		17. INFORMANT Mrs. Linda A. Perovich, Elkton, Md. 21921				ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary thromboses</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriovenous anastomotic fistula</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> to <u>1-26</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED 1-26-85
22b. SIGNATURE <u>Terrell, Layne</u>			22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rolando N. Jera M.D.</u>			22f. ADDRESS 105 E. Main Street, Elkton, Md. 21921								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-29-85		23c. NAME OF CEMETERY OR CREMATORIAL Bouldens Chapel Cemetery			23d. LOCATION CITY OR TOWN Elkton, Maryland		STATE 21921	
24. FUNERAL DIRECTOR <u>Paul E. Hicks</u> ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. 21921							25a. DATE REC'D. BY REGISTRAR FEB 1 1985				25b. REGISTRAR'S SIGNATURE <u>Paul E. Hicks</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other transitory event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 5 0 1 8 3 9
1 - STATE REGISTRAR					REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		FIRST GIBSON	MIDDLE H	LAST GOFF JR.	2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23, 1985 9:20PM
3. SEX <input checked="" type="checkbox"/>		4. RACE <input checked="" type="checkbox"/>	5. DATE OF BIRTH MONTH DAY YEAR 8 20 17		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 67 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <input checked="" type="checkbox"/>		7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <input checked="" type="checkbox"/>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <input checked="" type="checkbox"/>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <input checked="" type="checkbox"/>
13a. STATE <input checked="" type="checkbox"/>		13b. COUNTY <input checked="" type="checkbox"/>	13c. CITY OR TOWN <input checked="" type="checkbox"/>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST GIBSON		MIDDLE H	LAST GOFF SR	15. MOTHER'S MAIDEN NAME FIRST JESSIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT RUTH GOFF	ADDRESS PERRYVILLE MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 3, 1985 to JANUARY 23, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JANUARY 23, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <i>Jean Pouyes MD</i>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEAN T. POUYES, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD	
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/>		23b. DATE 1-28-85	23c. NAME OF CEMETERY OR CREMATORIAL BOTHET		23d. LOCATION CITY OR TOWN COUNTY STATE CECIL CHESAPEAKE CITY MD
24. FUNERAL DIRECTOR <input checked="" type="checkbox"/>		FOARD FUNERAL HOME, CHESAPEAKE CITY, MD		25. DATE REC'D. BY REGISTRAR 25a. REGISTRAR'S SIGNATURE JAN 29 1985 John A. Foard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8501840
1. DECEASED NAME (TYPE OR PRINT) EDWARD W. HAMILTON			2a. DATE OF DEATH JANUARY 19, 1985	2b. HOUR 8:15A M	
3. SEX Male		4. RACE White	5. DATE OF BIRTH Sept. 21, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST David		MIDDLE A.	LAST Hamilton	15. MOTHER'S MAIDEN NAME FIRST Delia MIDDLE McGovern LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 163-07-2016		17. INFORMANT Rose Hamilton 1987 Old Neck Road Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: POSSIBLE PNEUMONIA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (he) (she) attended the deceased from DECEMBER 27, 1985, to JANUARY 19, 1985, that (he) (she) last saw the deceased alive on JANUARY 19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (Did) (Did not) view the body after death.					
22b. SIGNATURE <i>Dilip S. Kittus, M.D.</i>		22c. DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DILIP S. KITTUS, M.D.		22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 23, 1985	23c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Cemetery	23d. LOCATION CITY OR TOWN Chester	STATE Pennsylvania
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR JAN 24 1985		25b. REGISTRAR'S SIGNATURE <i>JAN 24 1985</i>	
BATEMAN FUNERAL HOME, BROOKHAVEN, PA.					

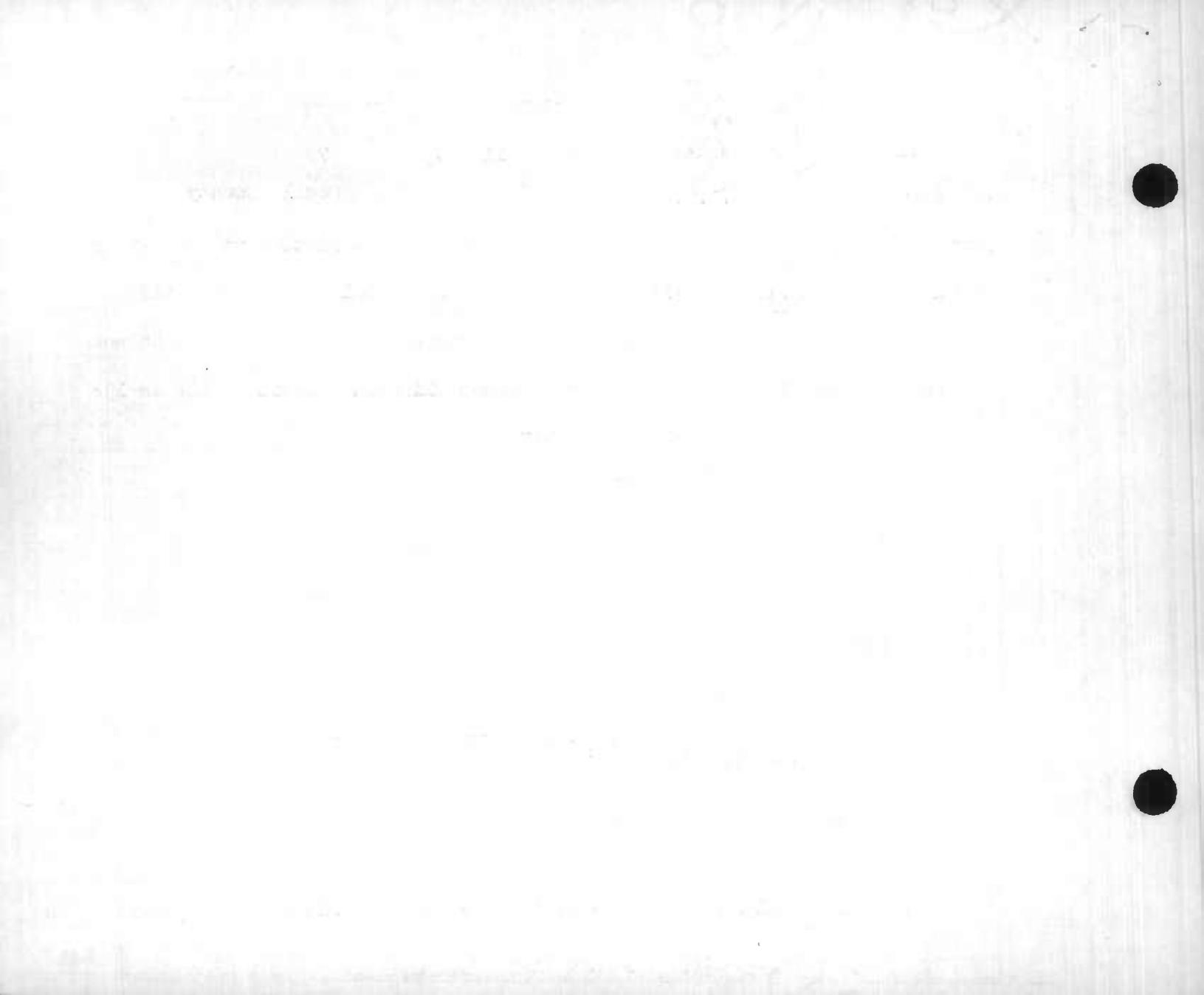
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, the burial permit should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8501841				
						REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FRANCIS G HEBERT			2a. DATE OF DEATH MONTH DAY YEAR				
1. SEX			4. RACE			5. DATE OF BIRTH				
Male			White			MONTH 3 DAY 11 YEAR 05				
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
Louisiana			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County				
10. CITY OR TOWN OF DEATH Perryville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent				
13. STATE Maryland			13. COUNTY A.A.			12b. KIND OF BUSINESS OR INDUSTRY Paper				
13. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 111 3rd Avenue 21225				
14. FATHER'S NAME FIRST 0 MIDDLE LAST Hebert			15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 327 05 2097			17. INFORMANT Susan Elizabeth Hebert Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a),						ADDRESS				
RESPIRATORY FAILURE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 17 19 82 to JANUARY 26 19 85, that (I) (we) last saw the deceased alive on JANUARY 26 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						COUNTY	STATE			
22b. SIGNATURE George Parry MD						DEGREE	22c. DATE SIGNED 1/26/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 1/29/85	23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem Park	23d. LOCATION Baltimore	23e. COUNTY Howard	23f. STATE Md
24. FUNERAL DIRECTOR NAME GEORGE GONCE FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR JAN 30 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson Randall			
ADDRESS BROOKLYN PARK MD										

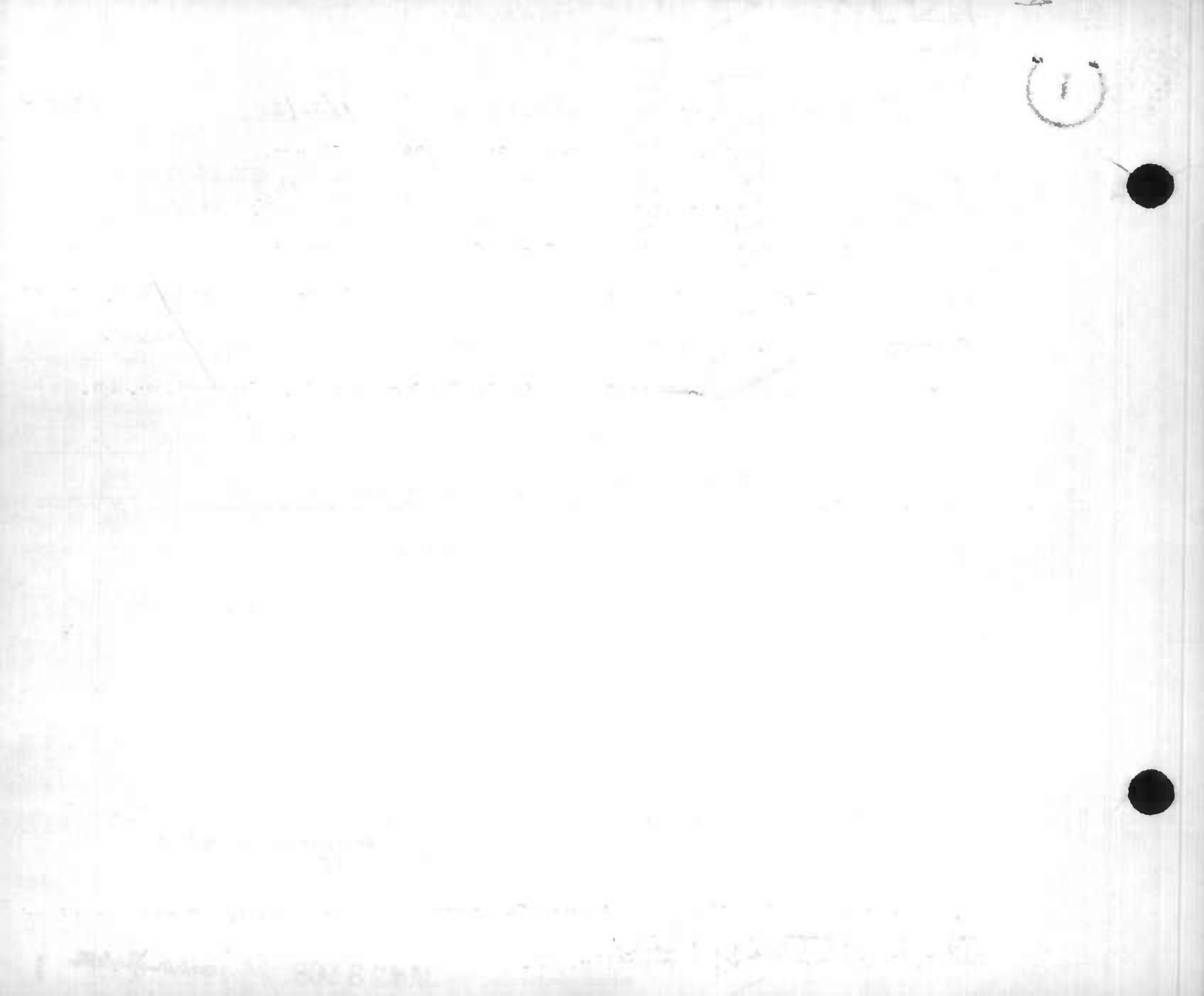


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or after traumatic event, the medical examiner may be notified or cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501842		
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE OF DEATH		
MARLENE			A				JACKSON			1/20/85		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR		
Female			White		MONTH May DAY 24 YEAR 1934			50 yrs.		13:50 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
New York			U.S.A.					Cecil Co			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Elkton			Union Hospital of Cecil County		Housewife			-----				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Cecil		Perryville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		816 Jackson Station Rd. 21903		
14. FATHER'S NAME			MIDDLE		LAST			15. MOTHER'S MAIDEN NAME				
Clarence			J.		Stevens			First Betty M. Parker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
NO			577-44-3898		Lewis R. Jackson, Jr.			Perryville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
CARDIAC ARREST ANOXIC ENCEPHALOPATHY 1 week.												
DUE TO, OR AS A CONSEQUENCE OF 1b) MYOCARDIAC INFARCTION												
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF 1c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
			P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1-20-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on above. (1) (we) did not view the body after death.										22b. SIGNATURE <i>Ehsanur Rahman</i>		
22c. DEGREE MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 1/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 2102 DRUMMOND PLAZA NEWARK, DE 19711									
EHSANUR RAHMAN												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial			Jan. 23, 1985		Asbury Cemetery			Port Deposit		Cecil	Maryland	
24. FUNERAL DIRECTOR See A. Patterson & Son, Perryville, Md.			25b. DATE REC'D. BY REGISTRAR							25b. REGISTRAR'S SIGNATURE		
										JAN 28 1985 <i>John Swanson</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8501843				
1 - FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
JAMES Rawlings JONES					January 31, 1985				11:35 pm	
3. SEX MALE		4. RACE CAUC.	5. DATE OF BIRTH AUG. 3, 1900		6. AGE 84		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7. BIRTHPLACE MILLINGTON		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED X NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL				
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VA Medical Center		12a. USUAL OCCUPATION MILL WORKER		12b. KIND OF BUSINESS OR INDUSTRY MILL				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13b. COUNTY KENT	13c. CITY OR TOWN MILLINGTON	13d. INSIDE CITY LIMITS? YES X NO		13e. STREET ADDRESS P.O. BOX 116		ZIP CODE 21651		
14. FATHER'S NAME CORBET		MIDDLE	JONES	LAST	15. MOTHER'S MAIDEN NAME JENNY		MIDDLE	LAST BAKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO. WW I 147-12-3553		17. INFORMANT EMILY ANNE JONES wife same		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastroenteritis, acute</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia, bilateral lower lobes</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericardial adhesions, diffuse, fibrous</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES X NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 28, 1985, to January 31, 1985, <u>XXXXXXXXXXXX</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. R. GARCIA, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-1-85				
THE PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS VAMC, Perry Point, Md.								
23a. BURIAL, CREMATION, REMOVAL SPECIAL BURIAL		23b. DATE 2/4/85		23c. NAME OF CEMETERY OR CREMATORIAL HURLOCK V.A.CEM.		23d. LOCATION HURLOCK, DORCHESTER, MD				
24. FUNERAL DIRECTOR NAME Fellows & Sons Funeral Home, Millington, Md.		25a. DATE REC'D. BY REGISTRAR FEB 1 1985		25b. REGISTRAR'S SIGNATURE Suzanne Pendell						
ADDRESS										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the medical examiner if item 18 is marked or if item 21 is important.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8501844				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Robert			D.						Knauss, Sr.			January		5, 1985		12:40 pm
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR			8 IF UNDER 24 HRS			
Male		White		August 7 1915			69 yrs.			YRS			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Pennsylvania		USA								Cecil						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Port Deposit		85 Burlin Road		Engineering Svc.			V.A.M.C., Perry									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												Point, Md.				
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 85 Burlin Road			21904			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
Charles		C.		Knauss			Blanche						Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		-----		213-07-1135			Ellen K. Bradley			111 Burlin Road Port Deposit, Md. 21904						
DUE TO, OR AS A CONSEQUENCE OF (b) Terminal 2a of Prostate																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost sow the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 1/1/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
Eddie S. Saw, M. D.			135 W. Main St., Elkton, Md. 21087													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE				
Cremation			Jan. 8, 1985			Cratin & Ferris			West Chester			Chester Penn.				
24. FUNERAL DIRECTOR Dee A. Patterson, Son, Perryville, Md.									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE JAN 14 1985				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do it.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 5 0 1 8 4 5					
										REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		1-28-85			3:00p M		
Ralph			L.			Lanphar									
3. SEX			4 RACE			5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
Male			Caucasian			12 28 02		82			YRS.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MI			US A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Cecil County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Elkton			Union Hospital of Cecil County			RETAIL Manager. Hotel									
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		17 Colonial Circle					
MD		Cecil		North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17		2 P.M.					
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST		16. SOCIAL SECURITY NO.			ADDRESS				
Daniel R. Lanphar						Elizabeth Raser		386-03-4730			17 Colonial Circle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			North East, Md. 21901						
Yes			1-8-21			Ralph R. Lanphar									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										51 hr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										Cordal arrest					
DUE TO, OR AS A CONSEQUENCE OF (b)										Arteriosclerotic heart disease					
DUE TO, OR AS A CONSEQUENCE OF (c)										10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 1982, to _____, 1985, that (I) (we) last saw the deceased alive on _____, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										1/28 1985					
22b. SIGNATURE Edgar E. Folk III										22c. DATE SIGNED 1/28/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk III, M.D.										22e. ADDRESS Union Hospital, Elkton, Md. 21901					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 1-31-85			23c. NAME OF CEMETERY OR CREMATORIAL White Chapel Mem.			23d. LOCATION Troy Oakland Mich.			STATE			
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR JAN 31 1985			25b. REGISTRAR'S SIGNATURE John B. Rader		
Robert J. Curran															

600

2000-01-02

2000

Figure 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8501846					
												REG. NO.					
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b HOUR					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	January 3, 1985			3:09 AM								
Elizabeth C. Maloney																	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
Female			White		January 4, 1904		80			YRS							
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland			U.S.A.				Cecil County										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital									Retired Principal			21921		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland		Cecil		Elkton					1080 Frenchtown Road								
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST								
James				Maloney	Ellen				Gracey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
NO			219-18-7110			Ella Maloney			1080 Frenchtown Rd. Elkton								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN DEATH AND MORTUARY					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
(b)												Death Hypocalcification					
(c)												Cardiac Respiratory Arrest Acute Myocardial Infarction Cerebral Sclerosis Heart Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr</u> 19 <u>78</u> to <u>JAN</u> 19 <u>85</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>12/28/85</u> , and did not view the body after death.												22b. DATE SIGNED 1-3-85					
22c. SIGNATURE <i>Dr. Joseph G. Lanzi M.D.</i>												DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Dr. Joseph G. Lanzi M.D.												22e. ADDRESS 721 Bridge Street Elkton, Md.					
22f. BURIAL, CREMATION, REMOVAL (SPECIFY)			22g. DATE			22h. NAME OF CEMETERY OR CREMATORIAL			22i. LOCATION CITY OR TOWN			COUNTY	STATE				
Burial			Jan. 5, 1985			Immac. Conception			Cherry Hill			Cecil	Md.				
24. FUNERAL DIRECTOR NAME <i>George Funeral Home</i>												25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>JULIA DAVIDSON RONDELL</i>					
ADDRESS <i>Elkton, Maryland</i>																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if item 22b is checked, any injury, or other traumatic event, the medical certificate must be completed in Part 2.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 01847		
												REG. NO.		
1. FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		
PEARL I MORRIS												MONTH DAY YEAR		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR		
F			W			MONTH DAY YEAR			72			1/27/85 4:45 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.			US									CECIL MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
ELKTON			UNION HOSP						DYE WORKS					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Md			CECIL			CRYSTAL BEACH			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21919 CRYSTAL BEACH MA 2013		
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME					
WILLIAM			B			MORRIS			ANNA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS		
NO			169-180430						JENNY RICCI			311 E 20 th ST CHESTER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any									DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION			many yrs many yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: DIABETES, OBESITY														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from show the deceased in above, (I) (we) did not view the body after death.			1/26 1985			1/27 1985			1/27/85			19		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN		
Joann Rosenfeld MD														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED								
JOANN ROSENFELD MD			Box 415, CECILTON, MD 21913						1/26/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
Cremation			1-30-85			Cremation Specialist Media Del. PA								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
See Funeral Home			EKTon, Md			FEB 05 1985			P. L. Rosenfeld					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 8 4 8					
1 - FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
James		William				Murphy		Jan. 21, 1985					P. 2:35 M.		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS			
Male		White		Sept. 5, 1910				74		YRS.					
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Elkton, Md.		USA		X				Cecil		MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Elkton		Union Hospital		Ret. Penna.R.R.		Railroad									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21921					
55 Blossom Lane															
14. FATHER'S NAME		MIDDLE A.		LAST Murphy		15. MOTHER'S MAIDEN NAME		ADDRESS							
William						Anna		Elkton, Md.							
Mae															
LAST Moore															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
no		219-05-9806		Mary J. Murphy		Respiratory arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) eva, pneumonia															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c) Acute COPD, Emphysema															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
19b.		19b.		20a.		20b.									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I, this hospital) attended the deceased from 11/17 1972 to 1/21 1985, that (I, we) last saw the deceased alive on 1/21 1985, and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) (did) (did not) view the body after death.		22b. SIGNATURE Jui-Chih Hsu		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/22/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui-Chih Hsu		22e. ADDRESS 223 West Main St, Elkton Md. 21921													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-24-85		23c. NAME OF CEMETERY OR CREMATORIAL GEE FUNERAL HOME		23d. LOCATION CITY OR TOWN Elkton, Memento		23d. LOCATION CITY OR TOWN Elkton, Memento		23d. LOCATION CITY OR TOWN Elkton, Memento		23d. LOCATION CITY OR TOWN Elkton, Memento			
24. FUNERAL DIRECTOR NAME R. Deen		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE R. Deen									

24

10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

executed by the Hospital or attending physician.

10 FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked as Item 18 show only injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501849					
REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			2. FIRST MIDDLE LAST			3. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Julian B. Murray						Oct. 28, 1922			1000 AM						
SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS					
				Oct. 28, 1922			62								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.								
11. CITY OR TOWN OF DEATH Elyria		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Group Leader					
13a. STATE Delaware		13b. COUNTY New Castle		13c. CITY OR TOWN Newark			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 18 Augusta Dr. 19711					
14. FATHER'S NAME FIRST MIDDLE LAST George Murray		15. MOTHER'S MAIDEN NAME Julia								16. KIND OF BUSINESS OR INDUSTRY Fiber Company					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Betty B. Murray			18. ADDRESS 18 Augusta Dr. Newark, DE 19711			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA & + CARDIO MYPATHY															
DUE TO, OR AS A CONSEQUENCE OF (b) DELIRIUM TREMORS, ALCOHOL ADDICTION															
DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION PNEUMONIA + GASTRIC BLEED															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) this hospital attended the deceased from 11/8/85 to 11/14/85, that (I) we last saw the deceased alive on 11/13/85, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Gary Beste										DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Beste, MD										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial										23b. DATE Jan. 17, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Gracelawn Meml Park		23d. LOCATION CITY OR TOWN New Castle, DE	
24. FUNERAL DIRECTOR NAME Frank C. Mayer, Jr. 1000 N. DuPont Pkwy.										ADDRESS New Castle, DE		DATE RECEIVED FOR REGISTRATION JAN 25 1985			

HOSPITAL OR ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

1

HMH 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 5 0

1 - FOR
STATE
REGISTRATION

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
IV A m. PAINTER			1/1/85			6:50 P M					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	White	Dec. 31, 1962	81			MONTHS		DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.					
Virginia	U. S. A.	Cecil Co	MD.								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
EIKTON	Union Hospital of Cecil Co.	Housewife			99999						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Delaware	New Castle	Newark	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			# 6 Kipling Drive					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
William			Simmons	Sarah			Puffenbargar				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.				17. INFORMANT	
No						155-44-9195				William Simmons #6 Kipling Dr. Newark	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) respiratory failure											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.						(b) pneumonia					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/30 19 84 to 1/1 19 85, that (I) (we) last saw the deceased alive on 1/1 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 1/2/85					
22b. SIGNATURE Kenneth Lewis, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Lewis MD						22e. ADDRESS Middleton Del					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Jan 4, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Eglington Cemetery		23d. LOCATION Clarksboro		COUNTY Gloucester		STATE N.J.	
24. FUNERAL DIRECTOR NAME Gee Funeral Home						25a. DATE REC'D. BY REGISTRAR JAN 7 1985					
ADDRESS EIKTON, MARYLAND						25b. REGISTRAR'S SIGNATURE John Doe					

more people
already

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 8 5 1							
1 - FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR				
JOSEPH			A.			PATTERSON			January 28, 1985				10:25A M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 3, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 70 1 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.										
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) SELF EMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY PLUMBER										
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 108 MARKET STREET 21078						
14. FATHER'S NAME FIRST JOHN		MIDDLE FRANCIS		LAST PATTERSON			15. MOTHER'S MAIDEN NAME FIRST SADIE				MIDDLE		LAST RILEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT MRS. AUDREY PATTERSON			ADDRESS SAME AS #13e										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) Cachexia and cardio pulmonary failure																	
DUE TO, OR AS A CONSEQUENCE OF (c) prostate Extensive metastatic lesions due to cancer of																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 20, 1984, to January 28, 1985. XXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <i>Julian Ocejo M.D.</i>				DEGREE		22c. DATE SIGNED 1-28-85	
22d. PHYSICIAN'S NAME JULIAN OCEJO, M. D.		22e. ADDRESS VA Medical Center, Perry Point, Md.						ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>					
23a. BURIAL, Cremation, Removal (SPECIFY) BURIAL		23b. DATE 31JANUARY85			23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN HAVRE de GRACE, HARFORD CO., MD.									
24. FUNERAL DIRECTOR NAME Mitchell Funeral Home, Havre de Grace, Md.		ADDRESS 21078			25a. DATE REC'D. BY REGISTRAR JAN 29 1985			25b. REGISTRAR'S SIGNATURE <i>L. Davidson-Randall</i>									

SAFETY RISK
JULY 16, 1982

SATURDAY

July 16

10000, Fairholme AV, 600, 1976

10000, 1976

10000, 1976

10000, 1976

10000, 1976

XXXXXX 10000, 10000, 10000

20-00-1

10000, 10000, 10000, 10000

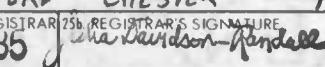
10000, 10000, 10000, 10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be

returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/master permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 01852						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Horace M. Reburn										JAN 30 1985				10 P M		
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS			
F	CAUCASIAN			MONTH DAY YEAR			91			MONTHS DAYS			HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania	U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			CECIL MD.									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
CALVERT MD.	CALVERT MANOR NURS Home, Inc.										House wife					
12b. KIND OF BUSINESS OR INDUSTRY																
13a. STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Pa.	Berks		OXFORD		YES <input type="checkbox"/> NO <input type="checkbox"/>		402 LARGE Rd.		19363							
14. FATHER'S NAME	LAST			15. MOTHER'S MAIDEN NAME			LAST									
WILMER	McINTYRE			ANNIE			Huss									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No	189-36-491			William W. Shepherd			902 Shady Side Rd.			Oxford, Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										second year						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										second year						
(b) AS CO VD																
DUE TO, OR AS A CONSEQUENCE OF (c) AS CO VD																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
CVA: hypertension; renal failure																
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)												
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-19-84 to 1-22-85, that (I) (we) last saw the deceased alive on 1-25-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE										DEGREE						
										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS						
G. Horco mbe										OXFORD, PA. 19363						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE			
BURIAL	2/14/85			OXFORD			OXFORD			CHESTER			PA			
24. FUNERAL DIRECTOR NAME	ADDRESS										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Richard L. Grodin, Rising Sun, Md.											FEB 05 1985					

3946.28

3946

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/Transit Permit. Then please remove carbon copies. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be certified on item 21.

MEDICAL CERTIFICATION

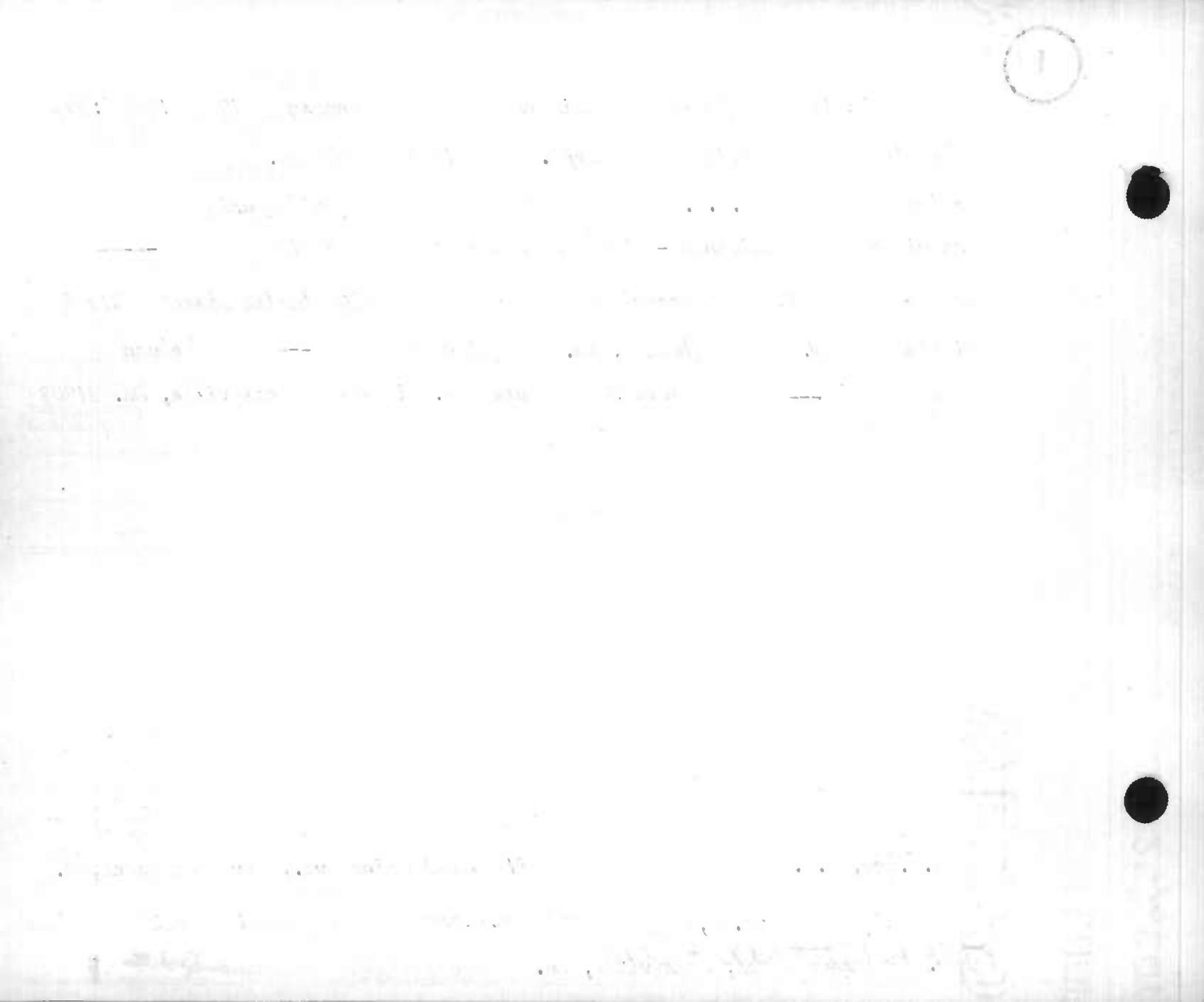
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8501853

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Nolie Charsha Simmers						January	19	1985	3:30 p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Sept. 9 1900		84 yrs.		YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Cecil County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Perryville		Residence - 620 Charles Street		Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Cecil		Perryville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		620 Charles Street		21903	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
William		W.		Charsha, Sr.		Elizabeth		---		Reburn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		---		Unknown		Joseph W. Simmers		Perryville, Md. 21903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) AS COOD											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Hypertension											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Old COA											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/20/85 to 5/24/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J.J. Lee, M.D.		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. ADDRESS 319 South Union Ave., Havre de Grace, Md.		22d. DATE SIGNED 5/24/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Jan. 22, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery		23d. LOCATION CITY OR TOWN Port Deposit		COUNTY		STATE	
24. FUNERAL DIRECTOR P. H. Hatterson & Son, Perryville, Md.		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JAN 28 1985			

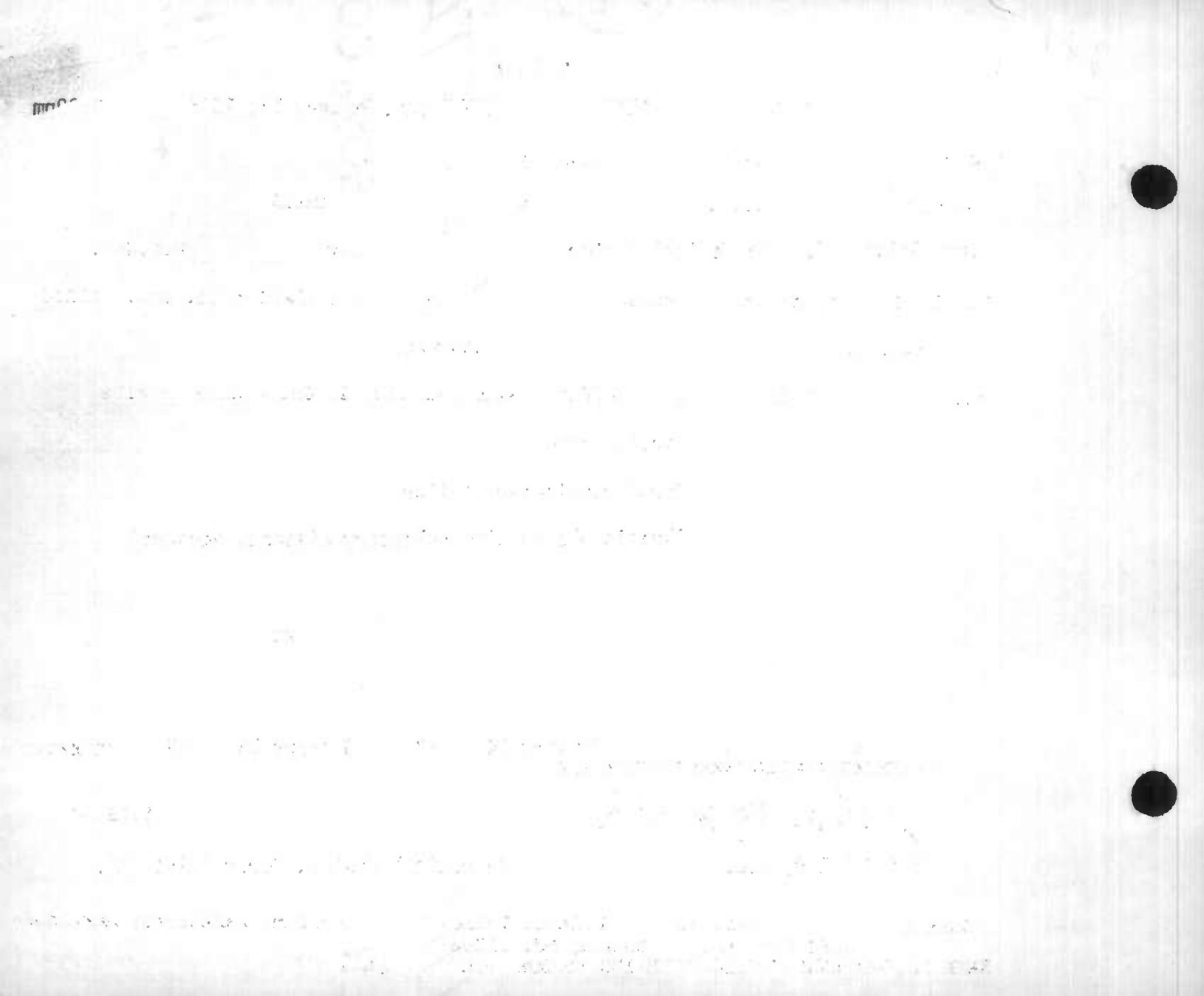


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8501854				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
CLEMENS						ARTHUR			TITTEL, SR.			January 14, 1985				3:20pm
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH DAY YEAR			82			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Germany			U.S.A.						Cecil							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Perry Point, Md.			VA Medical Center			Army			U.S. Gov.							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			503 Charles St. Ave. 21204				
Maryland			Baltimore			Towson			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
14. FATHER'S NAME			FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME			LAST				
			Unknown						Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes			WW II			230-38-7585			Clemens A. Tittel, Jr. - Same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																
Cardiac arrest																
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiorespiratory failure																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease, advanced																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 24, 1983, to January 14, 1985, <input type="checkbox"/> XXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.																
22b. SIGNATURE JULIAN OCEJO, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED 1-14-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEJO, M.D.			22e. ADDRESS VA Medical Center, Perry Point, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-17-85			23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley			23d. LOCATION CITY OR TOWN Timonium, Baltimore, Maryland			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME HKKX RUCK-TOWSON FUNERAL HOME INC TOWSON MD.			25a. DATE REC'D. BY REGISTRAR JAN 16 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandale										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85018552

FIRST (TYPE OR PRINT)			MIDDLE	LAST	REG. NO.
CLIFFORD			M.	VEASEY	1:20pm
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 15, 1922	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil Co., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed	12b. KIND OF BUSINESS OR INDUSTRY Plumber		
13a. STATE Md.	13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Mechanics Valley Road 31901	
14. FATHER'S NAME FIRST: John H. MIDDLE: Veasey LAST:	15. MOTHER'S MAIDEN NAME FIRST: Esther MIDDLE: LAST: Rea				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) yes	16b. SOCIAL SECURITY NO. WW 2	17. INFORMANT Virginia M. Hessey	ADDRESS Elkton, Md. 77 Hollingsworth Manor		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Cardio respiratory arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <u>Severe chronic obstructive pulmonary disease</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure and renal failure</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 28</u> , 19 <u>84</u> , to <u>January 21</u> , 19 <u>85</u> XXXXXXXXXX XXXXXX XXXX XXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Julian Ocejo M.D.</u>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1-21-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEJO, M.D.	22e. ADDRESS VAMC, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-14-85	23c. NAME OF CEMETERY OR CREMATORIAL North East Meth Cem.	23d. LOCATION CITY OR TOWN North East	COUNTY Cecil	STATE Md.
24. FUNERAL DIRECTOR NAME Gee Funeral Home, Elkton, Md.	25. DATE RECORDS REGISTERED JAN 2 4 1985	25. REGISTRAR'S SIGNATURE <u>Julie L. Anderson</u>			

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TO HOSPITAL OR ATTENDANT
retained by the hospital
TO FUNERAL DIRECTOR
should be detached for use
with the State Dep't. of Health
IMPORTANT: Item 21 is

226. SIGNATURE above, (if (we) (did) (did not) view the body after death, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the cause shown the deceased died (this hospital) offered the deceased from _____, 19 _____, to _____, 19 _____)		227. DATE SIGNED	228. ATTENDING PHYSICIAN MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	229. ADDRESS	230. PHYSICIAN'S NAME (TYPE OR PRINT)								
231. BURIAL, CREMATION, REMOVAL	232. DATE	233. NAME OF CEMETERY OR CREMATORIUM	234. LOCATION	235. CITY OR TOWN	236. COUNTRY								
<table border="1"> <tr> <td>237. (SPECIFY) BURIAL, CREMATION, REMOVAL</td> <td>238. DATE</td> <td>239. NAME OF CEMETERY OR CREMATORIUM</td> <td>240. LOCATION</td> <td>241. CITY OR TOWN</td> <td>242. COUNTRY</td> <td>243. STATE</td> </tr> </table>						237. (SPECIFY) BURIAL, CREMATION, REMOVAL	238. DATE	239. NAME OF CEMETERY OR CREMATORIUM	240. LOCATION	241. CITY OR TOWN	242. COUNTRY	243. STATE	
237. (SPECIFY) BURIAL, CREMATION, REMOVAL	238. DATE	239. NAME OF CEMETERY OR CREMATORIUM	240. LOCATION	241. CITY OR TOWN	242. COUNTRY	243. STATE							
<table border="1"> <tr> <td>244. FUNERAL DIRECTOR</td> <td>245. NAME</td> <td>246. ADDRESS</td> <td>247. DATE REC'D. BY REGISTRAR</td> <td>248. REGISTRAR'S SIGNATURE</td> <td>249. DATE REC'D. BY REGISTRAR</td> <td>250. REGISTRAR'S SIGNATURE</td> </tr> </table>							244. FUNERAL DIRECTOR	245. NAME	246. ADDRESS	247. DATE REC'D. BY REGISTRAR	248. REGISTRAR'S SIGNATURE	249. DATE REC'D. BY REGISTRAR	250. REGISTRAR'S SIGNATURE
244. FUNERAL DIRECTOR	245. NAME	246. ADDRESS	247. DATE REC'D. BY REGISTRAR	248. REGISTRAR'S SIGNATURE	249. DATE REC'D. BY REGISTRAR	250. REGISTRAR'S SIGNATURE							

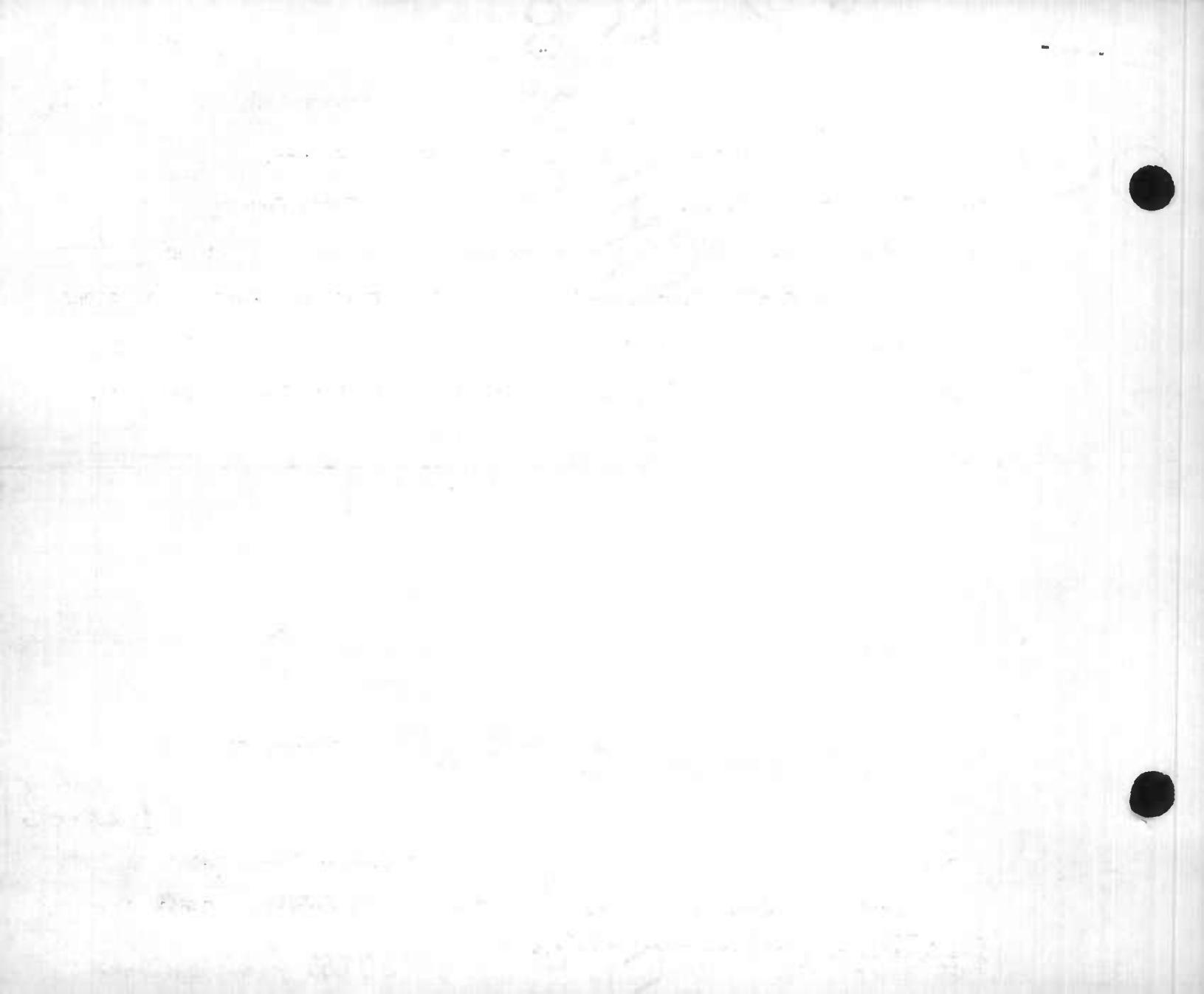
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and initially filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or hem 18 shows any injury or other traumatic event, the medical examiner must be notified at 310-732-3100.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8501856				
					REG. NO.				
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
	Wallace			January 23, 1985				5:35A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
Male	White	Feb. 3 1925		59 yrs.	YRS.	MONTHS	DAY	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
North Carolina	U.S.A.		Cecil County						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point	VA Medical Center, Perry Point, MD			Sheet Metal Worker					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
Maryland	Cecil	Port Deposit	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Craigtown Road	21904				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST		
	William	A.	Willien	Edna		---	Perkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS						
Yes	1943-1945	Richard W. Willien, Port Deposit, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
Acute Respiratory Failure									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 10, 1985, to January 23, 1985, that (I) (we) last saw the deceased alive on January 23, 1985, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.									
22b. SIGNATURE	DEGREE			22c. DATE SIGNED					
Prem Lal.	M.D.			ATTENDING PHYSICIAN	<input checked="" type="checkbox"/> MEDICAL DIRECTOR	STAFF PHYSICIAN	1-23-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS								
Prem Lal.	VA Medical Center, Perry Point, MD 21902								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION						
Burial	Jan. 25, 1985	St. Mark's Cemetery	Perryville	Cecil County Maryland					
24. FUNERAL DIRECTOR Patterson + Son	25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
	AUDIT			JAN 29 1985 John K. Jordan, Registrar					
Patterson and Son, Perryville, MD									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501857	
										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST Margaret	MIDDLE B.	LAST Wright	2a. DATE OF DEATH January 25, 1985			2b. HOUR 9:45 AM
3. SEX		4. RACE			5. DATE OF BIRTH MONTH Sept. DAY 2, YEAR 1890			6. AGE (IN YEARS LAST BIRTHDAY) 94			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7b. BIRTHPLACE COUNTRY Newisville, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil			MD.
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY at home			
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 224 E. Main Street,		21921	
14. FATHER'S NAME FIRST James		MIDDLE Anderson		LAST		15. MOTHER'S MAIDEN NAME FIRST Josephine		MIDDLE		LAST Cox	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-38-4434		17. INFORMANT Jane Hughes		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		ADDRESS Palmyra, Pa.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.	
						Acute myocardial infarction					
				Arteriosclerotic cardiovascular		DUE TO, OR AS A CONSEQUENCE OF (b)		disease		over 10 yrs.	
						DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from NOV. 15, 1972 to Jan. 25, 1985, that (I) (we) last saw the deceased alive on Jan. 23, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ralph Andrews</i>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1/26/85				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Andrews, M.D.		22g. ADDRESS 233 E. Main St., Elkton, Md.									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1-30-85			23c. NAME OF CEMETERY OR CREMATORIUM Kemblesville Cem.		23d. LOCATION Kemblesville Chester Co.				
24. FUNERAL DIRECTOR GEE Funeral Home Concordance EIKTON, MD		24b. ADDRESS JAN 31, 1985			25d. DATE READY FOR BURIAL REGISTRAR'S SIGNATURE <i>John G. Johnson</i>						

